2. USE LETTER QUALITY TYPE, NOT DOT MATRIX TYPE

IDENTIFICATION DATA

85540

A. Reporting A.I.D. Unit: Mission or AID/W Office (ES: Santo Domingo)

B. Was Evaluation Scheduled in Current FY Annual Evaluation Plan? Yes [X] Slipped [ ] Added [ ]
Evaluation Plan Submission Date: FY ___ Q ___

C. Evaluation Timing: Interim [ ] Final [X] Ex Post [ ] Other [ ]

D. Activity or Activities Evaluated (List the following information for project(s) or program(s) evaluated; if not applicable, list title and date of the evaluation report.)

Project No.	Project /Program Title	First PROAG or Equivalent (FY)	Most Recent PACD (Quarter)	Planned LOP Cost ($000)	Amount Obligated to Date ($000)
517-0229	Family Planning Services Expansion	9/86	8/93	$6,950	$6,950

ACTIONS

E. Action Decisions Approved By Mission or AID/W Office Director Action(s) Required	Name of Officer Responsible for Action	Date Action to be Completed
Mission will continue supporting family planning/population activities and will also begin supporting selected primary health interventions under the Mission's new Family Planning and Health Project (517-0259). (Project Agreement signed June, 1993).	GDO/PDO	12/93
PACR to be completed.	Lisa Usher	8/93

(Attach extra sheet if necessary)

APPROVALS

F. Date Of Mission Or AID/W Office Review Of Evaluation: (Month) (Day) (Year)

G. Approvals of Evaluation Summary And Action Decisions:

	Project/Program Officer	Representative of Borrower/Grantee	Evaluation Officer	Mission or AID/W Office Director
Name (Typed)	Lisa Usher J. Thomas	N/A	Luis González	R. Rifenburg
Signature	Lisa Usher J. Thomas		Douglas Chiriboga	R. Rifenburg
Date	7/28/93 7/29/93		8/9/93	8/19/93

ABSTRACT

H. Evaluation Abstract (Do not exceed the space provided)

The project aims to expand the availability of family planning information and services to low-income Dominicans.

Since July, 1990 the project has been implemented by the Dominican Association for Family Well-Being (PROFAMILIA); the Dominican Association for Family Planning (ADOPLAFAM); the Population and Employment Division of the GODR's National Planning Office (ONAPLAN); and the GODR's Maternity Hospital Nuestra Senora de la Altagracia (MNSA) (the latter through a buy-in to AVSC).

The final evaluation, based on a review of project activities, documents and interviews with project personnel, was designed to assess the impact of project activities, and to provide recommendations for the design of the follow-on Family Planning and Health Project.

Major findings are:

- Most Project targets will be met or exceeded by the PACD of August, 1993.

- Contraceptive prevalence increased from 31 to 37 percent of all women and gross fertility declined from 3.7 to 3.3 children per woman during the period of the projec' as shown by the results of the 1986 and 1991 Demographic and Health Survey.

- PROFAMILIA and ADOPLAFAM greatly improved their institutional capacity to manage family planning programs, and both made progress in recovering costs from fees for services and contraceptives sold.

- The development of a platform for the future formulation of a national population and development plan received important support within the project.

The evaluators noted the following recommendations and lessons learned:

- The adoption of a Population Policy requires mobilizing multiple agencies and sectors over a lengthy period of time.

- Projects involving the Government which are designed and approved before a new administration takes office should provide for contingency planning, and the political environment should be reassessed before the new project is ready for implementation.

- Private sector FP providers require continued assistance to grow and mature.

- Private sector family planning programs are a complement, and not a substitute for government services.

- Technical assistance is successful when it is jointly agreed upon by grantees and the donor.

COSTS

I. Evaluation Costs

1. Evaluation Team Name	Affiliation	Contract Number OR TDY Person Days	Contract Cost OR TDY Cost (U.S. $)	Source of Funds
Alberto Rizo, M.D.	independent consultant	IQC 517-0000-I -2275-00	$31,744	PD&S
Gabriel Ojeda, MPH,PhD.	independent consultant			

2. Mission/Office Professional Staff Person-Days (Estimate) 10 days

3. Borrower/Grantee Professional Staff Person-Days (Estimate) _____

A.I.D. EVALUATION SUMMARY – PART II

SUMMARY

J. Summary of Evaluation Findings, Conclusions and Recommendations (Try not to exceed the three (3) pages provided)
Address the following items:

- Purpose of evaluation and methodology used
- Purpose of activity(ies) evaluated
- Findings and conclusions (relate to questions)
- Principal recommendations
- Lessons learned

Mission or Office:	Date This Summary Prepared:	Title And Date Of Full Evaluation Report:

1. **Purpose of the Evaluation and Methodology Used** – The final evaluation was designed to provide an impact evaluation of project activities, with recommendations for the design of the Mission's follow-on Family Planning and Health Project. Due to early problems in implementing the project with the Government of the Dominican Republic (GODR) and resulting changes in the project design, no mid-term evaluation was conducted; as a result, the final evaluation was the only evaluation performed for the project.

The scope of work required two evaluation specialists to assess project strategy, performance of the participating agencies, and effectiveness of the technical assistance provided by the institutional contractor, for the three major components of the project: 1) family planning service delivery, 2) institutional strengthening of the implementing agencies, and 3) population policy promotion.

The evaluators spent a month in the Dominican Republic interviewing project personnel and reviewing project activities and documents that addressed issues such as institutional capability, management information systems, cost recovery, training, service delivery capacity, client education, and activities funded under Project Buy-ins to SOMARC, AVSC, and IRD/Macro.

2. **Purpose of the Activity Evaluated** – The goal of the project is to improve the quality of life of Dominican families by increasing their access to voluntary family planning services.

The purpose of the project is to improve and expand a public/private network of family planning service delivery outlets to meet the demand for voluntary family planning services by low-income persons and couples.

While the original project design emphasized the role of the public sector, subsequent problems resulted in an early change in project strategy to one oriented primarily toward the private, non-profit sector.

The project attempted to achieve its goal and purpose through three major project components:

1. family planning service delivery
2. institutional strengthening of the implementing agencies, and
3. population policy promotion

3. **Findings and Conclusions - Major Achievements:**

(Family Planning Service Delivery)

- Most of the Project targets will be met or surpassed, by August, 1993.

- During the life of the project, as shown by data from the 1986 and 1991 Demographic and Health Surveys (DHS), the contraceptive prevalence rate improved from 31 to 37 percent for women in fertile age, and from 50 to 56 percent for those women married or in union. The total gross fertility rate declined from 3.7 to 3.3 from 1986-91.

- Contraceptive supply increased through the private sector, which became the main service provider in the country (64.7%).

(Institutional Development)

- PROFAMILIA and ADOPLAFAM greatly improved their institutional capacity to manage Family Planning programs.

- Both PROFAMILIA and ADOPLAFAM made progress in recovering costs from fees for services and contraceptives sold.

- The technical assistance firm, Development Associates, Inc., was instrumental in helping the participant organizations strengthen their financial and administrative capacity, and was effective in carrying out its procurement functions.

(Population Policy Promotion)

- The development of a platform for the future formulation of a national Population Plan received important support within the project.

4. **Principal Recommendations**

- A.I.D. should continue providing Population program assistance to PROFAMILIA, ADOPLAFAM, MNSA and ONAPLAN, to allow them to complete the process already begun.

- Technical Assistance should continue to be provided to PROFAMILIA, ADOPLAFAM in the following areas in particular:

  * Use of data for decision-making;
  * Cost accounting and financial self-sufficiency;
  * Strategic planning for groups with special needs (e.g., male, adolescents, birth spacing);
  * Operation research techniques to assess Program effectiveness.

- Presidential Candidates for the '94 national elections and their advisors should become involved in population information sessions in order to obtain public support.

- Family Planning programs should include male contraceptive and adolescent services, and be designed to meet the needs of rural and illiterate clients.

- For the follow-on project, A.I.D. should select an institution to carry out the function of overall monitoring and supervision.

- Family planning agencies should coordinate more closely in identifying goals, planning activities, resolving problems, and evaluating results.

- The A.I.D. regulations should be explained to Grantees, as the working environment is far different from that in the U.S. and compliance may be difficult. It is essential that the Mission provide this guidance.

5. Lessons Learned

- The adoption of a Population Policy requires mobilizing multiple agencies and sectors over a lengthy period of time.

- Projects involving the Government which are designed and approved before a new administration takes office should provide for contingency planning.

- The political environment should be reassessed before the new project is ready for implementation.

- Private sector FP providers require continued assistance to grow and mature.

- Private sector family planning programs are a complement, and not a substitute for government services.

- Technical assistance is successful when it is jointly agreed upon by grantees and the donor.

ATTACHMENTS

K. Attachments (List attachments submitted with this Evaluation Summary: always attach copy of full evaluation report, even if one was submitted earlier; attach studies, surveys, etc. from "pre-ocular" evaluation, if relevant to the evaluation report.)

Project Final Evaluation Report

COMMENTS

L. Comments By Mission, AID/W Office and Borrower/Grantee On Full Report

The Family Planning Services Expansion Project is a Mission success story. The project made significant contributions to the institutional development and increased service delivery capacity of the Dominican private, non-profit family planning sector. It also supported both private and public sector demographic research and analysis leading to the development of national population/family planning policies, and supported the development of a highly successful post-partum contraception and physician training program in the GODR's largest maternity hospital.

Despite a problem-ridden public sector family planning system, the country made significant progress towards decreasing fertility and increasing contraceptive prevalence during the life of the project, according to data from the 1986 and 1991 DHS surveys. At the same time, the role of the private sector in providing family planning services also increased. The Mission project clearly played a role in those advances.

The project's final impact evaluation was a comprehensive review of project activities. In accordance with the scope of work, it provided an opportunity for an in-depth review of the project's outputs and productivity. It helped focus attention on the importance of assessing output per service delivery point and cost per service or CYP in assessing program performance, and has prompted increased interest of participating organizations in family planning evaluation techniques.

A.I.D. concurs with the conclusions of the evaluation, and has taken into consideration the major recommendations during the design of its forthcoming family planning and health project.

FINAL EVALUATION

FAMILY PLANNING SERVICES

EXPANSION PROJECT

(517-0229)

By

Alberto Rizo, MD, MPH
Gabriel Ojeda, Ph.D.

February 1 - 28, 1993

Document prepared for the Agency for International Development
USAID/Santo Domingo, Dominican Republic

by the International Development Assistance Company
under Contract IQC # 517-0000-I-2275-00 work order #4

TABLE OF CONTENTS

Family Planning Services Expansion Project Evaluation

Basic Project Information

Region:	Latin America and the Caribbean
Country:	Dominican Republic
Project Title:	Family Planning Services Expansion Project
Project Number:	517 - 0229
Project Dates:	Authorization : 9/08/86 First Amendment : 7/12/90 Second Amendment : 6/25/92 Termination Date : 8/31/93
Implementation Method:	
Grantees:	The Dominican Association for Family Well-Being, PROFAMILIA The Dominican Family Planning Association, ADOPLAFAM The National Planning Office, ONAPLAN Maternity Hospital Nuestra Señora de Altagracia (MNSA)
Technical Assistance Firm:	Development Associates, Inc.
Principal Activities:	Direct support to PROFAMILIA, ADOPLAFAM, ONAPLAN Buy-ins with AVSC, SOMARC and IRD/Macro
Previous Evaluations:	None

EXECUTIVE SUMMARY

1. Purpose of the Activity

The Family Planning Services Expansion Project (517-0229) was signed with SESPAS on September 19, 1986, one month after the inauguration of the current GODR administration. The original project was financed by a US$5 million A.I.D. grant and included US$1.7 million in counterpart contributions. The Project goal was to improve the quality of life of Dominican families by increasing their access to voluntary family planning services. The principal implementing agencies included SESPAS (CONAPOFA), PROFAMILIA, and ONAPLAN/DPE. CONAPOFA was expected to play a major role in implementing this project over the 5 year LOP period, ending September 30, 1992.

In October 1986, however, CONAPOFA was removed because it was not able to carry out its role as envisioned in the Project design. In July, 1990 A.I.D. changed the nature of the project when it approved amendments to the Project Paper. The amended project incorporated two new implementing agencies: the Dominican Association of Family Planning (ADOPLAFAM) and the Maternity Hospital Nuestra Señora de la Altagracia, in addition to PROFAMILIA and ONAPLAN from the original project. The Project amendment also added US$450,000 to the original project budget for a new LOP total of US$5,450,000 and extended the project assistance completion date by nine months to June 30, 1992.

A second amendment for $1.5 million was signed in June 25, 1992, which extended the PACD through August 31, 1993. Family planning services delivery became primarily the responsibility of the private non-profit sector.

2. Purpose of the Evaluation and Methodologies Used

The scope of work required two evaluation specialists to assess project strategy, performance of the participating agencies, and effectiveness of the technical assistance provided by the Project's institution/contractor, Development Associates, Inc. (DA). The evaluation will provide recommendations to be utilized in the design of the evaluation system for the Mission's next family planning project.

The evaluators spent one month in the Dominican Republic and conducted interviews with A.I.D. officials and officials of other institutions participating in the project. They also conducted file and document reviews, data analysis and provided personal observations of project-related activities. The Evaluation Report was originally written in Spanish. An

Executive Summary in English was also provided to USAID in accordance with the Scope of Work.

Project activities that addressed issues such as institutional capacity, management information systems, use of information, cost recovery, training, service delivery capacity, mass communication and client education, were assessed by the evaluators, as well as activities funded under Project Buy-ins to SOMARC, AVSC and IRD/Macro.

3. Findings/Conclusions

- Contraceptive prevalence rates for fertile-age women improved from 31 to 37 percent between 1986-91.

- Contraceptive prevalence improved from 50 to 56 percent for fertile-age women in union between 1986-91.

- Contraceptive supply increased through the private sector, which became the main service provider in the country. For example, in 1986 the public sector inserted 66.3 percent of IUDs and performed 40.2 percent of female sterilizations. In 1991, those percents were 34.3 and 36.7 respectively.

- Most of the Project targets will be met by August/93.

- PROFAMILIA and ADOPLAFAM greatly improved their institutional capacity to manage Family Planning programs.

- Both PROFAMILIA and ADOPLAFAM made progress in recovering costs from fees for services and contraceptives sold. PROFAMILIA increased its locally generated funds from 29 percent in 1986 to 50 percent in 1992. ADOPLAFAM improved its cost recovery from 9 to 20 percent in 1991 and 1992.

- The Demographic and Health Survey 1991 (ENDESA/91) funded under a Project Buy-in and conducted by IRD/MACRO and IEPD, provided useful information in Population and Maternal and Child Health.

- DA was instrumental in helping the participant organizations strengthen their financial and administrative capacity, and was effective in carrying out its procurement functions.

- The contraceptive prevalence rate is higher in Santo Domingo (60.7 percent) than in other areas of the country, and lower among illiterate women (41.5 percent), rural women, and for those with one child or no children at all. Male contraception is practically non-existent.

- Private sector family planning programs are a complement, and not a substitute for government services.

- The contraceptive method mix was not modified and female sterilization is still the most prevalent contraceptive method (39.2 percent). The pill follows sterilization as the number two method (9 percent). Female sterilization also has the highest prevalence in all regions of the country, both in urban and rural areas and among women with parity of 2 children and higher.

Conclusions

- The contraceptive method mix has not changed in the Dominican Republic.

- Although PROFAMILIA and ADOPLAFAM have improved their managerial capacity, they should continue receiving A.I.D. support to further strengthen their information systems and cost recovery.

- In spite of the Project inputs to PROFAMILIA and ADOPLAFAM, there are still regions of the country, like health regions IV and VI, rural areas,and women with less education that don't receive complete family planning information and services.

- The Dominican Republic still does not have an explicit Population Policy.

- Adolescent contraceptive programs are weak.

Recommendations

- A.I.D. should continue providing Population Program assistance to PROFAMILIA, ADOPLAFAM, MNSA and ONAPLAN, in order for them to complete the process that this Project helped initiate.

- Technical Assistance should continue to be provided to PROFAMILIA, ADOPLAFAM as follows:
  * Use of data for decision-making;
  * Cost accounting and financial self-sufficiency;
  * Strategic planning for groups with special needs (e.g., male, adolescents, birth spacing);
  * Operation research techniques to assess Program effectiveness.

- Presidential Candidates for the '94 national elections and their advisors should become involved in population information sessions in order to obtain public support. ONAPLAN, ADOPLAFAM and PROFAMILIA should coordinate this process.

- Family Planning programs should include male contraceptive and adolescent services, and should meet the needs of rural and illiterate clients.

Lessons Learned

- The adoption of a Population Policy requires mobilizing multiple agencies and sectors over a lengthy period of time.

- Projects involving the Government which are designed and approved before a new administration takes office, should provide for contingency planning.

- The political environment should be reassessed before the new project is ready for implementation.

- Private sector FP providers require continued assistance to grow and mature.

- The Mission should provide guidance in explaining A.I.D. regulations to Grantees, as the working environment is far different from that in the U.S. and compliance may be difficult.

- Technical assistance is successful when it is jointly agreed upon by grantees and the donor.

1. INTRODUCTION

1.1. Socio-demographic Situation

The Dominican Republic, along with Haiti, comprises the island of Hispaniola. The Dominican Republic spans 48,442 square kilometers.

The last census in the country, carried out in 1981, showed a population of 5,647,977 inhabitants. This figure indicates a population density of 117 inhabitants per square kilometer. The National Planning Office (ONAPLAN) estimates that the population will reach 7,620,391 for 1993. The national government is planning a new census for the current year.

Although the six national population censuses set up between 1920 and 1981 have been very useful, they form a database of very limited scope and exactness. They possess errors not only in coverage but also in internal consistency and quality of information.

Regarding vital statistics, the late registration and under registration of both births and deaths are often cited as among the most commonly occurring factors in the poor quality of the data.

For the evaluators, it was fortunate that the Demographic and Health Survey (1991 DHS) was finished and published, furnishing abundant, reliable information that represents the socio-demographic situation of the country. At the risk of sounding repetitive or supplying information already known, what follows is data that show the panorama of the variables related to the maternal-child population.

In the 1991 DHS, as with similar surveys carried out previously, the health region system of the Secretary of State for Public Health and Social Assistance (SESPAS) was adopted. This system defines eight health regions. This division coincides almost exactly with that which ONAPLAN employs.

In developing the field work for the survey, information was obtained from 7,144 homes; 7,320 women between 15 and 49 years of age were surveyed.

In the Dominican Republic in the last four decades, the population distribution by area of residence has undergone significant changes. Around 1950, almost 77 percent of the population was living in rural zones; in 1981 this figure had dropped to 48 percent. The 1991 DHS showed that the tendency toward progressive reduction of the rural population continued. Approximately 60.7 percent of the population now lives in urban areas.

The results also show women to have slightly higher education levels. Nineteen percent of males over six years old registered no educational background, in contrast with 16 percent of women.

Similarly, there was a greater percentage of women with secondary studies (19%), in comparison with 15 percent for the men. The greater percentages of educated women correspond to Regions VI and IV; Regions 0, II and III have the highest education levels.

The Dominican Republic has experienced a population decline in the last three decades. At the beginning of the 1960s, the total gross fertility (TGF) was 7.5 children per woman. In 1991, it was 3.3. However, a difference exists between the TGF in urban areas (2.8) versus rural areas (4.4). Similarly, while the TGF for the National District was 2.6, Regions IV and VI showed figures of 4.7 and 5.7 respectively. There are also important differences in fertility relative to education levels. The TGF for uneducated women (5.2) is double that of women with a university education (2.6).

The intervals with which women have their childrer is very interesting, not only because of the demographic implications, but also maternal-child health. Of the total number of births occurring in the five years before the survey, 36 percent had an interval of 24 months or less since their last birth, and the mean was 28. The spacing is a little further apart in urban areas and the National District. The births to mothers with a university education have a mean interval of more than 34 months, far above those corresponding to other levels of instruction.

According to the 1991 DHS, the median age of women at the birth of their first child is 20.9 years old, which indicates an increase of half a year above the 20.4 found in the 1986 DHS.

Something to consider in family planning programs is the reproductive behavior of adolescents. In the Dominican Republic, 13.4 percent of women between ages 15 and 19 were already mothers at the time of the survey, and 4.1 percent were pregnant with their first child. In other words, 17.5 percent had already begun their reproductive lives. This figure is double in rural areas (27%) what it is in urban areas (13%). According to regions, the percentages in Regions IV (33.9%) and VI (31.3%) more than triple the amount found in the National District (9.7%). The most significant variations are seen in relation to education levels; 44 percent of adolescent women without education have had children or are pregnant, while 11 percent of those with a secondary level education have.

Without any doubt, one of the main causes of the decline in fertility in a country is the knowledge and use of family planning methods.

In the Dominican Republic, family planning services are offered through the public and private sectors. The government program is under the responsibility of the National Council of Population and the Family (CONAPOFA), which is an agency attached to the Secretariat of State for Public Health and Social Assistance (SESPAS), created as part of decree 2091 on February 14, 1968, in order to study, research, analyze and make public all that is related to growth, mobility and population projection in the city. The governmental services are offered through approximately 700 establishments (hospitals, doctor and health offices, subcenters, dispensaries, rural and urban clinics) that SESPAS has distributed throughout the country.

Among the private entities that offer family planning information and services in the country are PROFAMILIA and ADOPLAFAM, as well as pharmacies and private doctors.

Knowledge of family planning methods in the Dominican Republic is practically universal among women of fertile age. The percentage who know of some modern method was 99.8 percent. However, while female sterilization and the pill were mentioned by 99.2 percent and 98.5 percent respectively, only 56.9 percent reported knowing about vasectomy and 57.3 percent about implants, tablets and foams.

It's one thing to know of the existence of family planning methods and quite another to know what they are, how they work and what the possible counterindications and side effects are.

In a study conducted by Orientación Mercadológica, S.A. (OMSA) under contract with Development Associates, Inc., the technical assistance firm contracted by the Agency for International Development (A.I.D.) under the Family Planning Services Expansion Project (517-0229), the focus group technique was employed with women between the ages of 12 and 30 and men between 25 and 40. They were from five geographic areas of the country: the Northeast, the Cibao, the South, the East and the National District, and from marginal, low, mid-low and middle socio-economic levels. This study concluded that:

- "The results show that participants of both sexes do not have a clear idea of what the concept of family planning is . . . "

- "One of the most revealing findings along this line is the ignorance of the women about their own bodies, failing to comprehend what ovulation consists of and when it occurs..."

- "The research showed ignorance about the components of the pills. The majority have the firm belief that these are not easily digested and can accumulate, forming pockets in the womb. Clarity about the counterindications and use do not

exist either. The main problem is that a large majority think they should not be taken daily, but rather minutes before sexual relations . . ."

- "Ignorance in many sectors about barrier methods, the subdermic implant and the injection and;

- "A general ignorance about the correct use of these and other methods . . . "

- "Regarding the IUD, two general myths exist that produce great fears and, therefore, the rejection of this method: the IUD causes cancer, and the child comes out with the apparatus stuck to its body . . . "

In another similar study, in which the focus group technique was also used with health workers, the following was concluded:

- "In all regions the belief exists that the pill sterilizes women who either take it before having had children or those who take it for too long . . . "

- "In all regions, a mix of lack of knowledge, disinformation, myths and negative beliefs about the IUD exists . . . . they ignore the contraindications of the method . . . "

- "Nurses interviewed have the same level of knowledge of Norplant as women who do not work in health professions."

The above statements confirm that information is incomplete and slanted. New campaigns, modified and well-planned, oriented towards the eradication of the myths and taboos are needed. In addition, correct knowledge of all contraceptive methods must be strengthened while services are being offered.

Thirty-seven percent of all women of fertile age and 56 percent of women who are either married or involved in relationships were using some contraceptive method at the time of the survey; this shows an increase of 6 percentage points over the survey of 1986. Worth noting is that 51.7 percent of these women use modern methods.

The percentage of use in the urban zones was 60.1 and 50.1 in rural areas. There are also important differences by level of education; while 66.3 of those women who have some university study plan, only 41.5 of those with no education do.

In the National District, the percentage of use rose to 60.7 and in Region II to 61.0, among women who are married or involved, while in Region VI, it was only 39.7 and in Region IV, 47.1.

Female sterilization is for many the main method, with 38.5 percent participation, followed by, though at quite a distance, the pill at 9.8 percent. The third modern method was the IUD with 1.8 percent.

In comparing responses according to the supply source among the Demographic and Health Surveys (DHS) of 1986 and 1991, one can see that the public sector is offering fewer family planning services (32.5). The private sector is the main supplier of all contraceptive methods (64.7); three of every four pill users obtained them from this sector, primarily from pharmacies. One of every two condom users also gets them in pharmacies, and six of every ten sterilized women had their operations in the private sector.

A significant and important fact is that of the 65 percent of women in union, including sterilized women who do not want more children, only 14.9 percent want a child soon and 17.0 percent prefer to wait.

It is also equally important that 40 percent of the births occurring in the country in the five years before the survey were not wanted (24 percent were not wanted at the time that they happened and 16 percent were definitely not wanted).

In the Dominican Republic, 17 percent of the women in relationships have unmet family planning needs: 8 percent in spacing and 9 percent in limiting. This need is greater among younger women, rural residents, those who live in Regions IV and VI and among those of lower socio-economic levels.

The 1991 DHS also showed that infant mortality (number of deaths of children under one year for each one thousand born alive) went from 46 per thousand between 1981 and 1986 to 43 per thousand between 1986 and 1991. The level of infant mortality is strongly associated with certain social characteristics; it is greater in rural zones, in Regions IV and VI, when the mother has had more than three children, when fewer than two years have passed since the last birth, if no attention was received during the birth and when the mother is under 20 or over 35 years old.

Ninety-seven percent of the mothers had prenatal care and 92 percent of the births since 1986 took place in health facilities. Only 37 percent of the children between 12 and 23 months old had complete immunization and 92 percent had been breastfed for some time.

1.1.1. Conclusions

All the data mentioned above regarding the quality of knowledge of contraceptive methods, the existing differences in the use of methods by type of contraceptive, urban and rural zones, regions of the country and levels of education, in addition to the very high percentage of women that do not want more children as well as the high percentage of unwanted children, demonstrate that a country like the Dominican Republic needs more structured and aggressive family planning activities and programs, aimed at supplying modern contraception to specific population groups that need to use these methods.

1.2. Family Planning Services Expansion Project (517-0229)

The Family Planning Services Expansion Project, signed September 19, 1986, was originally supposed to be in effect between 1986 and 1991. The objective was to increase the quality of life of Dominican families by improving their access to voluntary family planning services. Indirectly, this project was to have contributed to reducing the natural population growth rate from 2.5 percent in 1985 to 2.0 percent in 1991 and 1.3 percent in the year 2000.

The purpose of the Project was to improve and broaden the Dominican National Family Planning Program, providing greater access to family planning services for low-income families. When the project was signed on October 15, 1986, a goal of 300,000 new users was decided upon which, when added to the 300,000 already estimated, brought the projected total for 1991 to 600,000 for the end of Project ends. This figure was later modified to 805,555 Couple-Years Protection (CYP) to be completed in August of 1993.

The original Project proposed to strengthen and improve the structure and operating abilities of the main entities offering services in the Dominican Republic: The National Council of Population and the Family (CONAPOFA) and the Dominican Association for Family Well-being, Inc. (PROFAMILIA), so that both could not just expand their operations and handle a greater demand, but also strengthen their administration and reduce operating costs.

The strategy for implementing the Project was based on selecting CONAPOFA (from the governmental sector) and PROFAMILIA (from the private sector), since these two agencies had traditionally been the greatest providers of family planning services in the Dominican Republic. With their service networks, in 1986 they were responsible for approximately 60 percent of the contraception offered in the country.

At the end of the Project, the following situation was expected:

* Increase in the coverage of the National Family Planning program from 300,000 (19% of women of fertile age in 1985 to 600,000 in 1991 (33% of women of fertile age).

* Existence of a network of government and private clinics that offer family planning services in rural and urban areas inhabited by low-income families.

* Existence of a network of Community-based Distribution (CBD) services in the entire country.

* Systematic information and education activities of high quality through the mass media.

* Availability of demographic studies and analysis to improve the process of social and economic planning in the country.

* Staff development through human resources training as well as improving the management systems of the participating agencies from both the private and governmental sectors.

* Recovery of from 15% to 25% of the operating costs of PROFAMILIA and CONAPOFA through service charges.

The two main components of the Project in the beginning were:

(a) the expansion of family planning services and,
(b) institutional strengthening of CONAPOFA and PROFAMILIA.

To expand services, CONAPOFA and PROFAMILIA's CBD promoters network would be improved by training 4,500 promoters and supervisors. The supervisors would use a new manual developed to improve their performance. Similarly, the supervisors that were working in densely populated areas would receive motorcycles to facilitate their work.

The information and logistics systems (programming, warehousing, distribution and control of contraceptives) both in CONAPOFA and PROFAMILIA, would receive careful assistance to improve the quality of these systems.

PROFAMILIA, through its clinics in Santiago and Santo Domingo and associated clinics, would receive support from the Project in the form of improvement of its physical installations and the donation of equipment and supplies.

The number and variety of donated contraceptives would be enlarged, as well as services for the early detection of cervical cancer. Staff training improvements would be introduced for SESPAS/CONAPOFA and PROFAMILIA, and reforms in their information systems were proposed, along with innovations to introduce changes in the education of users of the services.

As a second component of the grant, technical assistance to improve CONAPOFA and PROFAMILIA's management capacity was included. That assistance was to consist of reviewing and updating the organization chart, better defining the roles of management, and introducing changes to the financial, accounting, logistics and information systems. Special emphasis in the aid package would be given to the accounting systems of CONAPOFA and PROFAMILIA to improve both cost calculation and information at the decision-making level of both institutions and adapt them to the needs and requirements of the donating agency.

Development Associates, Inc., (DAI) was selected as the agency to give technical assistance to the national agencies participating in the project: CONAPOFA/SESPAS, PROFAMILIA and ONAPLAN. A resident long-term consultant and one of medium-term had two permanent Dominican collaborators and counted on the support of an office in the capital to monitor the development of the Project and identify the technical assistance needs in areas such as cost, contraceptive logistics, information systems, acquisition of vehicles, computers and information management packages, financial systems, etc.

The expected results at the end of the Project and the amount of approved aid for the first five years of operation will be mentioned later in this report.

1.3 Development of Project Activities (1986-1990)

The Project was signed by the Director of A.I.D./Dominican Republic and the Dominican Secretary of Health on September 19, 1986, one month after the present Christian Social Reform Party (PRSC) government took office. Several days after taking office, the Executive Director of CONAPOFA was replaced. In his place, an official trusted by the current government was named. This person and others who were named to the Council soon proved to have limited technical preparation and did not show any inclination for understanding the commitments made by the previous administration in order to execute the Project according to the agreed-upon terms.

Besides progressively dismantling CONAPOFA, the staff already in place was replaced by selected officials with more of a party politics background rather than a technical one or one based on experience. As a consequence, CONAPOFA showed deficiencies in

the preparation and presentation of solid proposals that would guarantee the donating agency well-executed programs.

In spite of the efforts of the USAID mission and DAI to improve relations with the new functionaires at CONAPOFA and to continue the Project according to what had been established, the situation did not improve with the passage of time. The efforts to correct problems such as training deficiencies, and gain the confidence and obtain the cooperation of the Executive Director and the new officials named to CONAPOFA simply did not have the desired results.

Before the situation could improve, a series of administrative and resource management irregularities in CONAPOFA occurred. This led USAID to inform the Dominican government of the decision to suspend aid for the Expansion Project's component programmed for execution through SESPAS/CONAPOFA. (Letter to modify the development of the Project, no. 16 of May 3, 1989).

In the meantime, the activities programmed in coordination with PROFAMILIA and ONAPLAN were running as planned. The Executive Committee that had been arranged to coordinate the activities of the Project, comprised of representatives of SESPAS/CONAPOFA, PROFAMILIA, the Employment and Population Division (DPE) of ONAPLAN, DAI, and the AID Mission, was formed and meeting regularly.

The Project officially began activities at the end of 1987, when the paperwork to establish the DAI office in the country was begun, along with the recruitment and training of staff. In addition, development of basic studies in CONAPOFA and PROFAMILIA and a uniform system of statistics were initiated.

At that time, technical assistance was being offered, equipment acquired, and reports standardized, according to the terms and schedules agreed upon in the technical assistance contract (see trimester reports of DAI).

The project was modified in July of 1990 for the above reasons and the following changes were introduced:

- Suspension and withdrawal of the intended cooperation by USAID for SESPAS/CONAPOFA.

- The initially approved funds were reprogrammed and $450,000 was added, making the total amount of the Project $5,450,000.

- The Project was extended to June 30, 1992; nine months and eleven days after the original termination date (September 19, 1991).

- Two new institutions: the Maternity Hospital Nuestra Senora de la Altagracia (MNSA) and an NGO called the Dominican Family Planning Association (ADOPLAFAM) were invited to participate in the execution of the Project.

- As a consequence of the suspension of aid to SESPAS/CONAPOFA and the extension mentioned above, project goals were reprogrammed in all components, and the education component was defined in a much more explicit format. A mass media campaign to inform the population about temporary contraceptive methods was proposed.

- Additional studies were added to those that initially had been scheduled for action by ONAPLAN, such as the Family Planning Unmet Needs Study, etc.

- "Buy-ins" were signed with cooperating agencies, such as AVSC, SOMARC (The Futures Group) and the Institute for Resource Development (IRD) to develop activities in the MNSA (with AVSC), and PROFAMILIA (with SOMARC and IRD).

- It was agreed to maintain contact and coordination with the Dominican government through STP, the Technical Secretary of the Presidency of the Republic, which maintained support to the project in Dominican pesos equaling US$633,000.

- DAI'S contract was extended to June 30, 1992.

Between 1990 and 1992, a new modification of the project was agreed upon to prolong the execution time by 14 months, that is, from June 30, 1992 to August 31, 1993.

As a consequence of the approved extension, the goals of the project were reprogrammed and $1,500,000 was added to the budget for a total of $6,950,000.

The participation of DAI in the project was assured by the extension of financing, in order to continue its efforts in technical cooperation and coordination among the national agencies that develop the project activities.

1.4. Evaluation

Plans for the final evaluation of the project were finalized at the end of 1992 by A.I.D. in Santo Domingo. For that, two specialist evaluators were hired.

The two evaluators received information on the status of the project, documents with the project description, and plans and work reports of the participating national agencies in the first meeting held with representatives of the USAID mission, one day after their arrival in Santo Domingo.

During their first two weeks of work, the two evaluators visited PROFAMILIA, ADOPLAFAM, MNSA and ONAPLAN. They also made a trip to Santiago to observe the organization and operation of the PROFAMILIA clinic there. The PROFAMILIA clinic in Santo Domingo was also visited by both evaluators. The presence of both evaluators was preferred in all visits and interviews, rather than doing them separately. The agencies were asked for supplementary information that completed the periodic reports produced by each of them. The United Nations Fund for Population Activities (UNFPA) in Santo Domingo was also visited.

During their last two weeks, the evaluators worked on writing the evaluation report. During the fourth week of February, they made the necessary adjustments to obtain a final version, and presented the results obtained to A.I.D. and each of the participating agencies separately.

After the presentation of results and listening to the points of view of the agencies, final adjustments were made to the document and it was submitted to AID in Spanish to be translated into English later. A summary in English that A.I.D. requested from the evaluators was also submitted. Some observations of the evaluators deserve mention in this section:

First, the Family Planning Services Expansion Project was not evaluated upon completing the first half of its implementation.

Second, upon arrival in Santo Domingo the evaluators learned that a team of approximately 15 people, including various international consultants, had been working for several months on the preparation of the new family planning project that AID would finance for 7 years beginning in August of 1993, the termination date of the present project.

Third, the financial component of the project was not included within the terms of the contract and therefore, it was not evaluated. Similarly, the proposal approved for the evaluation did not include expenses for visiting the different services, especially the rural and marginal sites.

During the third week of work, a meeting was held, at which time the evaluators had the opportunity to comment in a preliminary manner on the results of their observations to members of the team working on the design of the new project.

The evaluators also listened to the preliminary ideas of those working on the new project.

The evaluators credit their perseverance to the broad cooperation of all people and institutions that were visited during the evaluation.

1.5. Characteristics of the Scope of Work:

On behalf of AID in Santo Domingo, the two evaluators were asked to determine the impact of and their opinions on the strategy employed, the design and the implementation of the Family Planning Services Expansion Project (517-0229). The objectives of this evaluation, in agreement with the scope of work prepared by AID were the following:

* Determine the effectiveness of the strategy, design and implementation of the project in achieving a better quality of life for Dominican families through greater accessibility to family planning services.

* Evaluate the participating agencies' fulfillment of project goals.

* Determine the effectiveness of DAI, contracted to obtain and deliver supplies and financial, technical and managerial assistance to the participating agencies.

* Recommend actions aimed at improving project strategy, design, goals, and implementation. Recommend output indicators that can serve as a basis for an evaluation system to monitor the next family planning project.

* Recommend the role that the technical assistance agency contracted for the next project would perform.

In the following chapter, the institutions involved in the project are described as well as the main results.

2. INSTITUTIONS

2.1. PROFAMILIA

PROFAMILIA, founded in 1966, is a private, non-profit agency affiliated with the International Planned Parenthood Federation (IPPF). Its main mission, in coordination with public and non-governmental agencies and institutions, is to strengthen and motivate the demand for family planning and contraception in the country, while also contributing to improving the quality of life in the Dominican population. To achieve this general objective, PROFAMILIA has established five fundamental strategies which are:

* Bring family planning services to different population groups to satisfy the real and potential demand for contraceptive methods, and integrate clinical services with maternal-child and laboratory care, on a cost recovery basis.

* Develop information, education and service actions aimed at specific groups so they can exercise their right to reproductive health and healthy, responsible sex.

* Increase the management and national and international human resource capacity through training in contraceptive techniques, family planning and administrative methods and techniques that contribute to increasing the efficiency of implementation and development of programs, projects and services.

* Develop opinion actions and influence the sectors with decision-making power about the importance of the population problem and its implication in development, so that demographic aspects are included in national development plans, and they establish a firm and coherent population policy in the country.

* Develop research, studies and actions that permit sustained institutional growth in programmatic and financial terms.

Within the Family Planning Services Expansion Project are the following components:

2.1.1. Institutional Clinics (Evangelina Rodriguez and Rosa Cisneros)

The main objective of these clinics is to offer family planning services, with an emphasis on highly effective methods integrated with maternal-child care and laboratory services, to the people of Santo Domingo (Northeast sector neighborhoods) and Santiago and neighboring communities, on the basis of service quality and recovery of direct costs.

The schedule of the Evangelina Rodriguez Clinic is 8:00 a.m. - 5:00 p.m., and that of the Rosa Cisneros Clinic is 8:00 a.m. - 12:00 p.m. and 2:00 p.m. - 6:00 p.m.

The Evangelina Rodriguez Clinic is located in a building adjacent to the Francisco Moscoso Puello Hospital. The Rosa Cisneros Clinic in Santiago is in a house owned by the city, loaned to PROFAMILIA for twenty years, with the option to buy. The first is being remodeled in order to broaden and improve the efficiency of the services offered.

The services offered are as follows: family planning, gynecological, obstetric, and pediatric office visits, basic laboratory exams, biopsies, pap smears, vaccines, ultrasound exams and the sale of contraception and some medications.

The Evangelina Rodriguez Clinic has a surgical area in which female sterilization services are offered (tubal ligation for minilaparatomy). They used to offer diagnostic laparascopy services. All surgeries are of an ambulatory nature. This clinic also has an area for biomedical research that occupies an important physical space in the clinic.

The clinic in Santiago does not have these services and has to refer patients requesting sterilization to associated clinics.

The sonogram machine at the Evangelina Rodriguez Clinic is owned by PROFAMILIA, purchased with the help of the Expansion Project, and operates from 12:00 - 3:00 p.m. The Santiago Clinic has one that operates from 12:00 - 2:00 p.m., and is owned by a doctor with whom cost and expenses are shared equally. In general, both sonogram machines are underutilized.

The two clinics offer all services at prices that are readjusted periodically according to inflation, but are lower than the prices on the commercial market. Low-income referrals from the Community-based Distribution Program pay lower prices. A large part of the medical services are contracted out.

Both clinics also have advisers/educators who develop educational activities, both individually and in small groups. These activities are supported by audiovisual material prepared by the central office and a video in each clinic with all-day projection.

As mentioned, the Rosa Cisneros Clinic in Santiago does not offer sterilization services. The current location of the clinic is the exclusive property of the city and leased to PROFAMILIA for a period of twenty years, renewable and with the option to buy, beginning December 11, 1992. PROFAMILIA is planning to remodel approximately 200 square meters, where they will have two floors. The first will hold the laboratory, secretarial area,

director's office and waiting room. The second floor will house the surgical area which is designed to facilitate circulation among the patients: waiting room, patient preparation room or area, operating room, recovery room, bathrooms, etc. The cost of remodeling will come to DR$685,703. The value of the equipment is close to DR$600,000 and the permanent staff per year, DR$130,000.

Charts 1 and 2 show the achievements of the main activities developed by the two clinics from 1987 to November 1992.

The Voluntary Sterilization Program began in the Evangelina Rodriguez Clinic in 1989 and since then it has grown. It could handle even more cases with the infrastructure that it has assembled. The number of consultations in this clinic is also on the rise year after year, except in 1990 which showed a decline.

The gynecological and family planning consultation figures began appearing separately in 1990. They were previously represented by only one figure. The pap smear shows falling results, along with other laboratory tests.

In the Rosa Cisneros Clinic, the IUD and implants show rising results, along with the number of consultations. The sale of condoms shows important oscillations because there was previously no Social Marketing Program. Cases have been seen where this program did not have some products in stock. When that happens, the clinic sales increase.

The laboratory tests of this clinic show important declines due to the fact that they previously offered blood typing and VDRL services to Free Zones. Now, because of high prices for the client, they have left the market. In addition, churches and NGOs are installing many laboratories in the zones that offer low prices.

2.1.2. Community-Based Distribution of Contraceptives

The objective of this activity is to maintain and increase the practice of contraception in urban, marginal and rural communities through the sale of temporary methods, and to establish a referral system for temporary and permanent clinical methods and medical tests. An additional objective is the development and dissemination of promotion, information and education to low-income population groups.

The project concentrates on the sale and/or donation of oral contraceptives, condoms and barrier methods obtained through donations from the Agency for International Development.

The basic means of contraceptive distribution is the promoter, who is a volunteer and receives only a small earnings through the sale of contraceptives and some special incentives when she manages to sell above the pre-established goal.

The promoter supervisors have the responsibility of supplying the promoters and training them at their ability and preparation level.

The community technicians are full-time employees of the institute and their responsibilities include training of the Promoter Supervisors and Promoters and supplying contraceptives.

Chart 3 shows the principle activities developed by this program and chart 4 shows the number of community technicians, promoter supervisors and promoters in December 1992, distributed by health regions.

The number of community technicians has risen from 9 in 1988 to 14 in 1992, and the distribution posts from 463 to 806; that is, they have almost doubled. However, the sale of oral contraceptives and condoms has not exhibited the same behavior.

In 1989 on average, each distribution post sold 493 cycles of oral contraceptives and in 1992, 459. The referrals have risen, which shows that while clinical services are needed in rural areas, people must be sent to a center in an urban area.

2.1.3. Associated Clinics

The objective of these clinics is to offer more temporary and permanent contraception to active and potential medium and low socio-economic level users at a national level through a network of private doctors. This action would then be complemented by reproductive health services and early cervical cancer detection.

The activities of the Associated Clinics are developed based on two principles: (a) the logic, motivation and functioning of the private commercial sector in the health area; and (b) the criteria of shared cost and responsibility.

During its operations, the institution detects clinics or centers interested in offering family planning services. According to the criteria described in the second principle, it evaluates them in terms of: physical presentation, equipment, technical plans, technical training of staff, etc. If the evaluation is positive, they sign an agreement or contract. This contract establishes the rights and duties of both parties, but does not require any modification of the operational norms of the clinic. The clinic only commits itself to complying with a

series of technical norms and quality standards established by PROFAMILIA for offering services under the agreement between the two institutions.

PROFAMILIA sells the clinics contraceptive methods at special prices that are lower than the rest of the commercial market. In addition, the institution gives or provides a package of surgical supplies necessary for each sterilization.

The centers or clinics offer their physical establishments and personnel for counseling services and activities. For the services it offers through this project, the center charges the patients a sum equal to 50 or 60 percent of what the service normally costs.

Within this project, there is a system of special referrals through coupons that waive payment. This system is managed by the staff of the Community-based Distribution Program and is dedicated exclusively to filling demands for sterilization, IUDs, pap smears and medical tests from people who cannot afford to pay for the services. Afterwards, PROFAMILIA reimburses the center a previously agreed upon sum for each of these services.

The institution also supports the centers with promotion and education activities such as talks, leaflets and educational materials. For information gathering and supplying of contraceptives, community technicians visit the corresponding centers.

The technical and administrative aspects are carried out by the regional directors and the executive technical subdirector, who is also the national project coordinator.

The main results of project services appear in chart 5. Oral contraceptive and condom use have increased, but female sterilization, although represented by a significant number, has decreased. In the life of the project, 39,246 tubal ligations have been performed, but of those, only 20,134 have been directly attributed to the project because the others had other sources of financing.

In December 1992, 96 associated clinics existed; 54 in the southern region (Region 0: 18, Region I: 15, Region IV: 6, Region V: 9 and Region VI: 6); and 42 in the northern region (Region II: 26, Region III: 8 and Region VII: 8).

This component of the project (associated clinics) received financial support through the Project until December 1991; afterwards, it received support from Pathfinder International.

2.1.4. Social Marketing

PROFAMILIA's Social Marketing program has not received direct financial support from the Expansion Project; however, through a "Buy-in" with SOMARC that began in April of 1991, it receives financial help for salaries and operating expenses, marketing costs, the IUDs that it distributes and the PROTECTOR condoms that come directly from AID or through an intermediary institution (IPPF).

The program buys Microgynon pills directly from the laboratory in Germany. Local prices are fixed according to the purchase price. The determined profit margins are the following: importers up to 67 percent, distributor 33 percent and pharmacy 30 percent. These margins are fixed by the Secretary of Public Health (SESPAS), to whom the final values must be reported.

The Social Marketing program always tries to maintain low prices on all the products so they will be accessible to the entire community. But the specific case of the oral contraceptives follows some general parameters such as:

a. That the price for the user not be greater than two percent of the minimum wage.

b. That the cost not be higher than two beers or a pack of cigarettes; the price of Microgynon to the consumer in the country is about RD$19 while similar products fluctuate between RD$60 and RD$190 in pharmacies.

Microgynon represents about 64 percent of the total sales of oral contraceptives in the Dominican market.

The country has about 2,500 pharmacies and the Social Marketing Program products presently arrive at 75 or 80 percent of them.

With respect to condoms, Protector and Escudo are sold, but the latter is very new in the market. Protector has about 24 percent of the national market and everything seems to indicate that it may be higher, since the measurement was made when there was a significant reduction in the stock of the program.

The products are promoted through the mass media. The campaigns are designed and executed by national companies and are developed periodically depending on the strengthening that is considered necessary.

The direct promotion to the doctors, in the same way as the sale to this group, is carried out through two promoters. The sale is made to distributors or wholesalers and from them, to pharmacies, supermarkets and grocery stores.

Periodically, market audits and related studies in this field are done. Presently they are done every year and contracted out to the firm OMSA.

Chart 6 shows the year by year results of the Social Marketing program. It is necessary to keep in mind that not all the achievements of this component are obtained with financing from the expansion project.

Since 1991, Social Marketing has distributed 10,989 IUDs, 187 implants, 1,280,372 cycles of oral contraceptives and 2,742,698 condoms. These are obviously important numbers within the context of family planning in the country. The data on condoms, which will be discussed later, is attributable to the project.

As Social Marketing has received financing through a "Buy-in" with SOMARC, this has created some confusion as to how and to what institution the results must be reported, since previously they received funding from central funds.

Besides the activities described earlier, PROFAMILIA conducts other services such as Reproductive Health and Family Planning for Teenagers in the San Carlos and Los Minas neighborhoods and peripheral areas, and Sexual Education through the Secretary of State for Education (SEEBAC). These activities, although not financed with project funds, are carried out through the interest that the institution has in reaching groups with unmet needs.

PROFAMILIA also has an administrative framework and an information and evaluation system that furnishes constant and continuous support for the service programs. These aspects will be discussed later in this report.

2.1.5. Global Results

In chart 7 results are presented in couple years of protection (CYPs) provided by the services financed by the project. For their estimation, the CYP factors suggested by AID were used, with the exception of the one corresponding to female sterilization, where a factor of 13.5 was based on local data collected by PROFAMILIA. The indicators appear in the lower part of the chart. The weight that the associated clinics have (around 42 percent) is due to the female sterilizations. The lower number of CYPs of the Rosa Cisneros Clinic is due to not offering female sterilization services.

2.1.6. Population and Development Studies Institute (IEPD)

The IEPD is another component of this project. With Project financing, they developed and published the following studies:

- Population and Education;
- Population and the Condition of Women;
- Agrarian Reform. Employment and Production of Food (not published);
- Population Projections by Gender, Age, Regions and Subregions;
- Employment Projections by Gender, Regions and Subregions;
- Population, Migration and Urban Development;
- Urban and Rural Population Projections by Age and Gender;
- Employment and Housing Projections by Regions and Subregions;
- Study of Unmet Family Planning Needs;
- The 1991 DHS, through a "Buy-in" with the IRD;
- Five Bulletins on Population and Development.

The final objective of all these studies was to create an information base on population and development of which groups in power could become aware. Their publications were received at all the executive and political levels of the country. They have achieved the following results:

- The theme of population stopped being a taboo and is talked about openly by politicians, communicators and planners;
- The theme of population has been positioned in the political and social context of the country;
- The theme has been included as an area of interest to researchers;
- The Dominican Congress created a Commission on the Family, Population and Development with the support of PROFAMILIA.

- The IEPD works in coordination with ONAPLAN/DPE.

2.1.7. Conclusions

- PROFAMILIA is the institution with the most experience offering family planning information and services. It is the largest private institution in this field in the Dominican Republic.

- It has a good institutional image in different circles in the country.

- Although the institution does not have national coverage in the strictest sense of the word, its participation as a source of services, according to the 1991 DHS, comes to 11.5 percent of the total. This is without taking the Social Marketing program into consideration, which offers about 250,000 CYPs a year. This indicates an important number of users who do not remain registered as users of PROFAMILIA in the study.

- Of the 808 promoters in December 1992, only 182 were living in rural zones and 626 in urban zones.

- The process of planning is based more on previous results, that is, on a historic process that seeks to reach or cover a target population to serve.

- There is little coordination between PROFAMILIA and other institutions that offer family planning services in planning and goal identification, regionalization of services and procedures to follow.

- The institutional clinics are working almost at full capacity offering family planning, obstetrical and gynecological services, but even more services can be managed, such as laboratories, pediatrics and sterilization in the Evangelina Rodriguez Clinic.

- Few systematic evaluations are done on information management and staff training. This should receive more emphasis.

2.2. ADOPLAFAM

The Dominican Family Planning Association (ADOPLAFAM), founded in 1987, is an NGO headquartered in Santo Domingo. Since its inception, it has developed activities directed primarily at informing, educating and bringing family planning services to people residing in marginal areas of Santo Domingo (Region 0, National District), and in Region 1 (Peravia, San Cristóbal, and

Monte Plata) and Region 5 (El Seibo, San Pedro de Macorísa, La Romana, and la Altagracia).

ADOPLAFAM has a Board of Directors made up of seven people connected by their interest in demography and its effects on social and economic development in this country. This institution, before being included as a participant in the Expansion Project beginning in January 1991, received support from the Enterprise Program to establish a network of community family planning services in neighborhoods inhabited by low income people in the capital. The strategy employed by ADOPLAFAM for getting people to use contraceptives included three components which they still maintain:

* A Community-based Contraceptive Distribution program (CBD) that uses community promoters called Volunteer Community Health Agents (vcha's).

* A second component consists of a network of doctors in popular neighborhoods to whom ADOPLAFAM has provided training in family planning and credit so that they can acquire instruments, equipment and contraceptives as well as provide family planning services for the people that go to their consultations for health reasons.

* The third and final component is based on the use of owners of beauty salons and barbershops established in popular sectors who, in addition to their regular services, offer information and sales of contraceptives to their regular clients.

ADOPLAFAM has received money donated by the United Nations Fund for Population Activities (UNFPA), USAID's Child Survival Project (CSP) operating in the Dominican Republic through University Research Corporation (URC), and donations from DAI, besides the funds already mentioned from the Enterprise Program.

The ADOPLAFAM offices are located in two sites near each other in a residential neighborhood of Santo Domingo, one block from one of the major east-west thoroughfares. Given the growth experienced in the last two years, ADOPLAFAM will soon move part of its staff to a third location near the other two, where they will be more comfortable.

The following are under the Executive Director: the administrative/financial area which consists of a chief and auxiliary staff; the services area which consists of a chief, three sector coordinators and three supervisors. For each twenty vcha's, there is a community worker who also supervises an average of ten OBS and between five and six units.

Finally, there is an Information and Development Education area, charged with supporting the service activities offered in

the community. Results achieved by ADOPLAFAM's programs with project financing are:

2.2.1. Volunteer Community Health Agents (vcha's)

The vcha's are people who live in marginal areas of Santo Domingo (Region 0, National District) and San Cristóbal. Before ADOPLAFAM entered the project, there were 150 vcha's. At the end of 1992, they had added 320 for a total of 470 of whom 83 percent were located in the National District (Region 0).

The vcha's are trained through short courses that are given for the staff in the Information and Education area of ADOPLAFAM, with the help of a manual that contains topics related to contraception and primary health care, to which the vcha's dedicate 40 percent of their time. As the name indicates, the vcha's work on a voluntary basis, but they receive health insurance, free basic medicine when they are sick and fifty percent of the sale of contraceptives from ADOPLAFAM in exchange for their services.

The vcha's are assigned an average of 35 homes to visit. Each "family" visited has a card on which the volunteer notes basic information on the people that comprise that family.

Using a factor of six people and 1.2 women of fertile age per family, the 470 vcha's have the potential to be in contact with some 19,740 women of fertile age and 98,700 people of all ages in one year.

The vcha's sell oral contraceptives and condoms and refer people when they need to see the community doctors that work with ADOPLAFAM.

During 1991 and 1992, this component provided a total of 10,861 CYP's, representing 44 percent of all the CYP's offered by ADOPLAFAM (chart 8).

It was not possible to know the exact figure recovered by ADOPLAFAM through the sale of contraceptives by the vcha's because the accounting system presently in use does not allow for the itemized accounting of income.

ADOPLAFAM's vcha's also develop primary health care activities in their communities, among which those under USAID/Santo Domingo's Child Survival Project are some of the most prominent. Approximately forty percent of their time is dedicated to these activities.

2.2.2. Community Doctors

The Community Doctors Program (CD) of ADOPLAFAM began by adopting the development model of MEXFAM (The Mexican Family Planning Agency affiliate of IPPF). This model gave credit to unemployed doctors to acquire equipment, instruments, supplies and a site for which rent and services were paid for a predetermined amount of time. The CDs were established in low income areas, and began by offering medical services that included family planning. It was expected that after some time, they would assemble a clientele and start to pay back the loan with very low interest.

Shortly, ADOPLAFAM discovered that this model did not work in the Dominican Republic. The doctors did not recover the costs within the agreed time (12-24 months). They were not maintaining the initial motivation and the number of users of family planning, and could therefore not guarantee the viability of the program.

The model that was substituted for the earlier one maintained the credits but reduced the amount of the loan to an average of US$200-500 that financed the doctor, who had already established some of the following elements in marginal areas:

Basic equipment includes that for the insertion of Intrauterine Devices (IUDs), oral contraceptives and barrier methods and other equipment such as "goose-neck" lamps, dry heat sterilizer, etc. The big difference between the initial model and the latest one mentioned is that with the latest one, the doctors are already established in a neighborhood and have made investments in staff and their own equipment.

The CDs are general practitioners, most are young, recently graduated from different Dominican medical schools and usually spend 4 to 8 hours per day in their clinics. During their initial contacts with ADOPLAFAM, it is determined whether they are interested in cooperating with the institution's programs and if they require training in family planning. Then they sign a contract that is approved by the Executive Director of ADOPLAFAM.

The CDs receive their family planning training in Santo Domingo in one of SESPAS's Health Centers that guarantees each doctor will insert 10 IUDs before receiving a certificate proving their suitability. ADOPLAFAM is in charge of making the contacts and guaranteeing that the training of the CDs is carried out with an acceptable length and intensity.

Before entering the project, ADOPLAFAM had some 25 CDs registered. At the end of 1991, they numbered 32. At the end of 1992 there were 53, which surpasses by three the goal to be reached by August of 1993. The CDs attend to referrals by the

vcha's and by the staff of the barber shops and beauty salons, especially when they require help with troubles related to the contraceptives that they use. All people referred to a CD by ADOPLAFAM personnel bring a coupon that has been agreed upon to arrange for their care. The referred person pays the equivalent of US$1-$2 to the CD, who then keeps the coupons and presents them to ADOPLAFAM to be reimbursed for the care provided.

The CDs buy the contraceptives from ADOPLAFAM to sell to their patients. The value of the purchase is: one cycle of oral contraceptives for $0.32; condoms for US$0.16 and an IUD for US$4.80. The prices for the public are fixed by each professional but ADOPLAFAM recommends that the profit margin not be greater than 30 percent. This control is difficult to achieve, however, because ADOPLAFAM lacks the instruments that permit them to regulate a market over which they have little control.

The insertion equipment and other instruments are sold to the CD at the price at which they enter the ADOPLAFAM storeroom. The credits granted are applied to the payment for these tools.

The information that results from the CD's family planning activities are reported in simple formats which detail: Date of consultation, gender, age of user, type of contraceptive prescribed and if the person came in spontaneously or was referred. Besides the consultations in family planning, the doctor reports primary care activities to ADOPLAFAM. The information is gathered monthly by a community worker from ADOPLAFAM in charge of the sector.

During the period 1991-1992, the CDs offered a total of 7,660 CYP's, which represented 31 percent of the total offered by ADOPLAFAM (chart no. 8).

2.2.3. Barber and Beauty Salon Operators Program (OBS)

This program is based on the fact that hairstylists in beauty salons and barbershops in zones inhabited by people of limited economic resources have daily contact with many people with whom they share information on topics of common interest.

The addition of family planning "as a theme to discuss with the clients" that came to these places would make it possible - at least in theory - to reach a large quantity of people using resources that exist almost all over the country.

ADOPLAFAM has registered about 376 beauty parlors (+ 59 barber shops) in the zones where it develops activities. The program provides a training that generally lasts one day. The OBS's receive basic knowledge about motivation and how to provide

information on condoms and oral contraceptives, methods that they sell to the people who visit their shops.

The supervision of the OBSs and the barber shops is the responsibility of the community health workers who participate in the training, supervise, obtain the information monthly and resupply the contraceptives in a regular form.

During the first year of the project, ADOPLAFAM trained 36 OBS and 89 barbershops. At the end of 1992 there were 376 beauty salons and 59 barber shops registered.

The OBS's and the barbers sell oral contraceptives and condoms. The money that they receive for this work does not represent an important profit for them. Their main motivation is to help the community.

During 1991 and 1992, this component offered 5,890 CYPs, which represents 24 percent of the total of ADOPLAFAM.

The main programs that ADOPLAFAM conducts with project funds are complemented by numerous Information and Education activities.

In 1991 and 1992 ADOPLAFAM trained 219 nurses and students in family planning; 77 doctors in contraceptive technology; 281 vcha's; 50 beauty salon operators; 33 community technicians and central office staff.

2.2.4. Conclusions

* The information discussed above leads to the conclusion that ADOPLAFAM is still an institution in formation whose coverage has been limited to some marginal areas of the capital and a few zones in Regions 0, I and V.

* The number of CYPs registered by ADOPLAFAM in 1991 and 1992 (24,411), represented at the end of November of 1992 3.0 percent of the total CYPs programmed to be reached by the Project in August of 1993 (24,411/806,555).

* The Volunteer Community Health Agents program contributes the greatest number of CYP's to ADOPLAFAM. Forty percent of the vcha's staff effort is dedicated to primary health care activities.

* In 1991 and 1992, ADOPLAFAM trained 219 nurses and students in family planning; 77 doctors in contraceptive technology; 281 vcha's, 50 beauty salon operators; 33 community technicians and central office staff.

* The Barbershop and Beauty Salon Operators Program contributes 24 percent of the CYPs of ADOPLAFAM.

* Even when ADOPLAFAM uses an accounting system that enables it to know the exact cost of services that it offers through distinct service programs, it is not completely integrated (for example, it does not account for the cost of donated contraceptives, nor does it itemize the total income per program, etc.).

* The current separation of staff in two offices, soon to be three, is not the best way to make the institution's operation more efficient, due to the extra time one must dedicate to communication among the different departments. Besides, fragmenting the institution creates confusion among the participants of the different programs.

* ADOPLAFAM is highly dependent on A.I.D. funding. It only recovered 9.18 percent ('91) and 19.8 percent ('92) from the sale of services in the three programs financed by the project.

* The vcha's program has the greatest number of CYPs. Despite this, each volunteer distributed 14 CYPs on average in 1992. The CD program, although it produces fewer CYP totals than that of the vcha's, registered 83 CYPs for each community doctor in one year due mainly to the IUDs inserted. The OBS distributed 9 CYPs on average in 1992.

* These figures indicate that an increase in the size of the present program would have a very limited effect due to the relative inefficiency of the three components producing CYPs.

* Given that two of the three components that the project finances have primary health care activities (CDs and vcha's), any evaluation of their efficiency using CYPs as the only indicators is in danger of being biased. It is essential to study to what point primary health care actions are a factor that favors the work of the CD and the vcha's.

* The proposed goals in the project are being met.

* ADOPLAFAM has developed the capacity to plan, design proposals for requesting assistance and support its programs with an information system that, however, still requires adjustments.

* ADOPLAFAM knows and has contacts with governmental institutions in the fields of health and education that could potentially be used as resources to broaden family planning information and services.

2.3. Maternity Hospital Nuestra Senora de la Altagracia

The program in this hospital was conceived as a medical activity for the prevention of reproductive and high obstetric risk. The "Buy-in" with AVSC made it possible to offer voluntary female sterilization, post-partum or post-miscarriage services in an area of the hospital.

The hospital handles between 20,000 and 25,000 births and about 3,000 incomplete miscarriages yearly. In addition to being a university teaching hospital for the medical school of the Autonomous University of Santo Domingo, it serves as a training center for medical students, interns, residents and doctors from other countries who are either in private practice or the service of their governments.

The goal of the project with AVSC is to guarantee that the patients of the hospital leave with a contraceptive method, taking reproductive health and risk into consideration.

Information is offered through a team of counselors and education. Various alternatives are offered, such as the IUD, oral contraceptives, barrier methods and condoms. As of yet, they do not work with Norplant because of the cost.

The IUDs are received from AVSC are Copper-T 380A. This service, which was offered intermittently prior to the program, is being offered post-partum and post-miscarriage as well as between pregnancies since September 1992.

The oral contraceptives (RIGEVIDON 28 of RICHTER) and the condoms (Sweet Home) are received from UNFPA through CONAPOFA. Those who use oral contraceptives are given three cycles every visit and those who use condoms are provided with an average of 20 units.

The female sterilizations are mostly done using minilaparatomy techniques, laparascopy or caesarian, which is used only when this operation is necessary at birth.

There are no requirements for participation in this program - not age or number of children. A clinical history is obtained but not processed. The statistics of the number of cases handled and some averages that are calculated manually are all that are taken. In February, the use of a new, more easily processed, precodified clinical history was initiated. Services are only offered from Monday to Friday.

Administratively, the director of the project is the director of the hospital. There is a doctor coordinator paid by the project who has responsibility for the entire technical-

administrative part, and four obstetrician/gynecologists, two paid by the project and two by CONAPOFA, distributed as follows:

One doctor in charge of the surgery area who practices surgery, coordinates the surgical area and provides training.

A consultation doctor for post-partum and post-miscarriage IUD insertion.

Two doctors in the outpatient area: one works from 8:00 a.m. to 1:00 p.m. and the other from 1:00 p.m. to 6:00 p.m., Monday to Friday. The surgical area also has the following personnel:

- An infirmary supervisor paid by the project;
- 6 aides paid by the hospital;
- A general services technician paid by the hospital.

The IUD, post-partum and post-miscarriage area, besides the doctor has:

- An educator paid by the project;
- A nurse paid by the hospital.

Each outpatient doctor has:

- A secretary paid by the hospital;
- An educator paid by the project;
- A nurse's aide paid by the hospital.

In the education area there are:

- A coordinator paid by CONAPOFA;
- Two educators paid by CONAPOFA;
- Three educators paid by the project.

Besides the above functionaries, there are also the following:

- A secretary
- A statistician
- An accounting assistant.

The project has a total cost of US$239,946, including the cost of remodeling.

In general terms, a good program has been developed from September of 1991 to November of 1992. They have carried out 3,153 tubal ligations, which makes an average of 197 in a month. During the same period, there were 1,557 people using IUDs and 910 using other methods, for a total of 5,620 or a monthly average of 351. The average number of surgeries or sterilizations has increased. Most important is that the quality that is offered in each case is better and could be a model not just at the national but also at the international level.

2.3.1. Conclusions

* Taking all the staff mentioned into account, it's necessary to study their roles and performance carefully so as to reduce their numbers and increase the efficiency of the program.

* The family planning services of Nuestra Senora de la Altagracia Maternity Hospital are good, especially the tubal ligations, even though they are far from the proposed goals (6,000 ligations and 3,000 IUD insertions).

* If it is taken into account that in the hospital more than 20,000 births and 3,000 incomplete miscarriages are handled each year, the coverage of family planning services should be increased in a significant manner, especially considering that the hospital handles high risk patients.

2.4. ONAPLAN

The National Planning Office (ONAPLAN) is a central government agency under the Technical Secretary of the Presidency of the Republic, which has responsibility for coordinating the preparation of the Sectoral Plans and Programs and their integration into the General Development Plan.

ONAPLAN entered the Expansion Project as a participating agency since its beginning through the Division of Population and Employment (DPE). This division is one of the technical offices of ONAPLAN that is in charge of integrating population as a component of its Development Plans and Programs. Consequently, ONAPLAN does not develop service programs directly like other participating agencies do.

The DPE of ONAPLAN was invited to participate in the project. In any country, a technical group like the one working in the DPE plays an important role in sensitizing the high spheres of government to the population situation and the role that it plays in different social and economic programs. This has been occurring in the Dominican Republic.

Specifically as a part of the project, the DPE received support to strengthen its population analysis capabilities. This enables them to incorporate demographic variables in the planning processes to help the government assign resources in a more equitable fashion.

The project provides help to the DPE through the following operations:

a. Donation of computer equipment and program packages.

b. Computer training of DPE staff and other ONAPLAN staff in technical aspects and the use of the software.

c. Dissemination of demographic information, including population projections and various studies carried out in the country.

ONAPLAN has participated in the project since 1988. Like the other agencies, each year it has submitted annual work plans to A.I.D. and the technical assistance agency (DAI), which are approved quickly. The payments were well-managed by DAI. The purchase of computers and items such as software packages, or the payment of airline tickets to facilitate the travel of DPE staff that went overseas on observation trips or to participate in training sessions was done without delays.

The main activities carried out by ONAPLAN, through the support of the project, are the following:

2.4.1. Population Report Bulletin

In November of 1989 the first example of the Population Report Bulletin was published in a series of five to disperse information on development and population.

The series included the following themes: Demographic Information for Planning (Nov. '89); 82% Population Registered for National Elections (May '90); Adjustment with a Human Face (April '91); and The Situation of Girls in the Dominican Republic (Dec. '91).

The bulletins have been well accepted. Two of them have received special coverage by the media due to the controversy that they caused at the time. The bulletin with electoral data was published only a few weeks before the May 1990 elections. Given that it cited figures about the number of inhabitants in the country by regions, which were very different from the outdated figures that the Central Electoral Board was using, it generated an exceptional debate on population in the media.

Bulletin no. 4 (Adjustment with a Human Face) dramatically documented the economic crisis of the country. It showed how adjustments to reduce public expenditure and inflation, efforts to bring the exchange rate of the Dominican peso to the U.S. dollar to its real price, and other measures recommended by the Monetary Fund would impact on the most vulnerable groups of the population: children, women and senior citizens.

The publicity of this document, some months after the economic measures were in full swing, helped a vast sector of the population understand the need to equalize the unfavorable situation of vast sectors of the population with social

strategies such as proposals to be put forward through the so-called Social Emergency Fund (SEF).

The project introduced a computerized system of text editing and assembly for the DPE that permitted the processing of graphic material and texts ready for printing.

2.4.2. Poster on "Demographic Indicators of the Dominican Republic"

This poster summarizes the main demographic indicators for the country by zones, planning regions and subregions for the period 1980 - 2000. It was distributed to a large number of public and private agencies. It was so successful that a full-color reprint was prepared exclusively for the Secretary of Education, Fine Arts and Culture (SEEBAC), to be distributed in schools, reaching all corners of the country.

To explain the data and the demographic variables contained in the poster, an instructional handbook was prepared to accompany it.

2.4.3. Participation in the 1991 Demographic and Health Survey (DHS II)

The Demographic and Health Survey of 1991 in the Dominican Republic was carried out through a contract (Buy-in) with IRD/Macro System. Carrying out the 1991 DHS was the responsibility of PROFAMILIA's Population and Development Studies Institute (IEPD); ONAPLAN collaborated in the coordination and analysis of the results.

2.4.4. Socio-demographic Data Bank

Since the beginning of the project, the directors of ONAPLAN have wanted to organize and implement a Socio-demographic Data Bank. This Data Bank will finally be functioning in March or April of 1993. All the preliminary work has been advanced with the cooperation of national experts through technical assistance from DAI.

It is the first time that the Dominican Republic has put a Population Data Bank to use. To begin activities, they have codified 294 socio-demographic variables of studies carried out in the country. They also have series of data produced by the different development sectors. The information that is stored in the Bank is from 1970 to 1990.

In the conceptualization of the Bank, in its planning and in the work carried out up to this time, such as the support of the ONAPLAN directors, the work advanced by the DPE staff which is charged entirely to the National Budget and finally, the role

played by DAI through the donation of computers and software packages, staff training, observation visits and the consultant contributions already mentioned have all been decisive.

Putting the Data Bank in operation has not been free of difficulties. For example: not all the data series are complete; many of them have had to be incorporated into the Bank using written reports instead of being copied from data files; other series are stored in languages that have to be translated into languages that are compatible with the programs used in the DPE Bank, etc. Add to this the fact that of the staff of the DPE and especially the staff in charge of filing the information, there are no more than three or four people who must attend to diverse demands on their time, aside from those required by the Data Bank.

2.4.5. ONAPLAN's Demographic Studies Center (DSC)

Finally, ONAPLAN presently works as the Technical Secretary of the future delegation from the Dominican Republic to the World Population Conference that will be held in Cairo in 1994. This delegation still has not been named, but the preparatory work that is required has been entrusted to the DSC.

2.4.6. The Population and Development Documentation Center of ONAPLAN (PDDC)

The PDDC is actually an appendix of the DPE and operates in the same building. Currently, it possesses some 2,000 titles and is consulted by students, professionals, university professors, researchers and by people of the different development sectors that require specialized information on population/development.

2.4.7. Migration Studies Unit; Survey Bank

This is a recently created unit within the DPE of ONAPLAN and is the responsibility of a suitable professional who will be in charge of all the coordination of studies, data and themes related to internal and external migration in the country. This unit receives advice from the Organization of American States (OAS) as well as from other organizations that support studies and promote policies concerning the migration phenomenon.

The Survey Bank is another of the projects that the DPE has planned for the near future. This Bank will facilitate Dominican researchers' access to surveys done in the country which contain information that can be analyzed at any time.

2.4.8. Conclusions

* The greatest strength of ONAPLAN and the obvious success of the project in selecting this dependency lies in the enthusiasm of the people that comprise the DPE and the support that they receive from the Directorate. With an organization consisting of barely ten people, between technicians and support staff, their production has been spectacular.

* The DPE of ONAPLAN has grown considerably, due to project support in the form of equipment, programs, staff training and technical assistance from DAI. The DPE has reached a level that allows it to be invited, listened to and taken into account by official circles where decisions about population are made.

* The DPE, through the Data Bank, the Documentation Center and the Population Report Bulletins, is an important emissary of population information in the Dominican Republic.

* One perceived weakness that affects not only ONAPLAN but also any project with similar characteristics in any third world country, is related to the dependency that these units acquire by relying on external financial support to maintain themselves in the vanguard and to acquire technology that permits them to meet goals like those of procuring, consolidating, storing and dispersing specialized information in order to respond efficiently to the needs of the clients.

* The adoption of an explicit population policy is a process whose beginning is difficult to predict. In the Dominican Republic, the current government of the PRSC, like its predecessors, adopted many population measures different from the "laissez-faire" policies that have predominated in the country up to the present.

* The evaluation team learned that the person in charge of the DPE was traveling to Brazil to continue his postgraduate studies in Demography. Although this experience represents a great personal gain for him and for the country, for the Project, it constitutes a great loss.

* Due to limited interest in population and the weakness of the National Statistics Office (NSO), this job has been assumed by the DPE. This is evident by the participation of the DPE instead of the NSO in the 1991 DHS. The economic statistics that the Central Bank manages, some in need of considerable improvement according to the technicians of the DPE, are an object of conversation among the technicians of this dependency and those of the Central Bank.

3. COSTS PER COUPLE-YEAR PROTECTION

The evaluators were asked to do an analysis of the costs of Couple-Years Protection of each institution and service. This proved quite difficult due to the lack of homogeneity in the accounting procedures and the assignation of revenue and costs in the different institutions. Here it is necessary to consider that under these circumstances, the results must be handled carefully and, whenever possible, definitive or categorical comparisons should be avoided. Similarly, because of time limitations, the evaluators could not go as deeply into this topic as they would have liked. The methodology and results were presented to each institution.

3.1. PROFAMILIA

In the case of PROFAMILIA, the data used were supplied by the Executive Subdirector for Administration and Finances. To the costs of each activity and for each year, 31 percent was added. This figure was obtained by Mr. Thomas R. Morris, Financial Advisor, as part of the technical assistance provided by DAI. This figure, which was used as a constant, is an estimate of the indirect costs or overhead. Next, the revenues of each activity were deducted to obtain the net cost. Finally, the difference was divided by the number of Couple-Years Protection offered by each activity during each period. Annual periods were used, beginning with 1988. The 1992 figures go to November, since there were no definitive data for the entire year at the time of the evaluation. The results found for each service and year appear in chart 11. All the figures are in Dominican pesos because of the variability of this currency against the U.S. dollar during the period of the project. It is necessary to consider various important points:

- The costs of all the activities increased significantly in 1990 and 1991, because of high inflation in the Dominican Republic, especially during 1989 and 1990.

- The lowest cost CYP is offered by the associated clinics, since there is no staff cost, no investment and material costs are very low. Besides, they have the CYPs of the sterilizations, which increase their numbers significantly.

- The difference between the cost of CYPs at the Evangelina Rodriguez and Rosa Cisneros Clinics is basically rooted in the fact that the Evangelina Rodriguez Clinic offers VSC service that provides many CYPs, even though the service itself is expensive.

- The costs of the CYPs in the Community-based Distribution Program have increased rapidly, due to the great

number of distribution centers that have opened without doing an evaluation of their efficiency and effectiveness.

To learn the level of program self-sufficiency, the revenue of each activity was related to the corresponding costs of that activity. The results appear in chart 12. The indirect costs were not taken into consideration here. The percentage of self-sufficiency or "sustainability" in the Evangelina Rodriguez Clinic increased from 25 percent in 1988 to 74 percent in 1992. During the entire project, it has been at 58 percent.

In the Rosa Cisneros clinic, self-sufficiency rose from 59 to 67 percent. In 1991 there was an important decline and the total for the entire project was at 60 percent.

The Community-based Distribution Program has been characterized by peaks and valleys: it rose to 27 percent in 1989 and then fell to 15 percent in 1992. The average for the period was 18 percent.

The associated clinics show lower levels and an 11 percent average. However, one must remember that it is the cheapest CYP that PROFAMILIA offers.

The Social Marketing data only correspond to the project and besides, its level of sustainability is high (43 percent).

In general, all the service activities of the project present an average level of self-sufficiency or sustainability of 44 percent and rose from 29 percent in 1988 to 50 percent in 1992, which indicates a continuing progress.

3.2. ADOPLAFAM

The accounting system that ADOPLAFAM employs, although it has been in use for many months, has not been used at full capacity to establish cost centers that permit the precise estimation of the real value of the services offered with project funds.

For example, in the regular accounting of the institution, the revenues through sales of services are combined, and it was not possible to separate them out once such an operation was done. These revenues are managed and reported separately. The costs of the vehicles and equipment, as well as the contraceptives, are not accounted for either, which makes it difficult to approximate a real cost per service.

It was decided, then, to opt for a CYP cost calculation per dollar spent by the project, which is a gross approximation.

In the CD component, approximately US$47,831 was spent in 1991 and US$69,035 in 1992. Relating these figures to the CYP show a cost for the project US$13.6 in 1991 and US$4.9 in 1992 (see chart 8).

It was not possible to know the exact figure recovered by ADOPLAFAM for the sale of contraceptives by the vcha's because the present accounting system does not permit a separate accounting of such revenues collected by this program or by the others developed by the institution.

The expenditures of the OBS's and barber shops component was US$23,915 in 1991 and US$34,517 in 1992, which indicates that the cost of each CYP rose to US$12.1 in 1991 and to US$8.8 in 1992 (see chart 8).

ADOPLAFAM is highly dependent on the funds that A.I.D. donates. It only recovered 9.18 percent in 1991 and 19.8 percent in 1992 through the sale of services in the three programs financed by the project (see chart 9).

3.3. Maternity Hospital Nuestra Senora de la Altagracia

In this institution, the calculation is more difficult, since there is no accounting that permits the clear assignment of expenditures, costs and revenue. As was already mentioned, during the life of the project (from September, 1991 to November, 1992), they have performed 3,153 sterilizations; if a factor of 13.5 CYPs per case is used, it gives a total of 42,506 CYPs. If that is related to the total cost of the project (US$239,946) for the number of CYPs, it yields a cost of US$5.64 per case; multiplying by RD$12.5 (rate in effect for the last two years) yields a cost in Dominican pesos of RD$70.50.

Logically one must consider that within the budget of this project there are remodeling and investment costs that make the CYP offered more expensive. Furthermore, there are many staff costs, inputs and installations that are paid by the hospital or CONAPOFA that are not considered and would raise the cost of the CYP.

4. INSTITUTIONAL DEVELOPMENT

The actions developed during the life of the expansion project that have contributed to the development of the institutions are different for each institution. Therefore, they will be covered separately for each institution.

4.1. PROFAMILIA

4.1.1. Management Information System (MIS)

The main objective of the MIS is to furnish truthful information to the management and directorate levels of the institution that is appropriate and homogenous about the results, costs and impact of the programs. This information is provided through the configuration of two large data banks: the financial and the statistical, in order to respond to the institution's programmed growth.

To achieve this objective, the Information System Department has been established, under the Subdirector for Planning and Development. It interacts and coordinates the information system with the other operative areas of the institution and furnishes the hardware and software needed, assuring that they are appropriate for their degree of development.

Specifically, through this department and with the financial backing of the project, they have carried out the following:

* Systematization of offices through the word processor (WP 5.1) and electronic mail (4 Pro).

* Acquisition of TECAPRO (Appropriate Technology, S.A), for the installation of the following applications:

  - Accounting, that has been in operation for two years.
  - Budget, both financial and programmatic, already in operation.
  - Bank Reconciliation, operating for six months.
  - Inventories, in the test stage.
  - Payroll, in a parallel stage.
  - Clinic Administration System (CAS), the part corresponding to inventories and cash register is in the operational phase. As of yet, they have not installed the clinical history section.
  - Check Processing, in the operative phase.

At the local level, PROFAMILIA has developed the following applications:

- Collection of data from the CBD program and associated clinics.

- Human Resources: employee final benefits and psychological evaluations.

- Automation of publications for the documentation of the IEPD and IEC.

4.1.2. Evaluation System

The Evaluation Department, with the help of the expansion project:

* Restructured administratively: it was relocated under the Subdirector for Planning and Development, since that is the institutional office most in need of such information. It also must work in close coordination with the Information Systems Department.

* Redefined the functions of storing, processing and analyzing the service statistics; systematically evaluating the programs of the institution; and planning and developing necessary operational research.

* As part of the above activities, they carried out a "Patient Flow Analysis" at the Evangelina Rodriguez Clinic that detected bottlenecks. The results were the basis for remodeling the clinic.

* Some of the new forms for collecting information were designed, tested and installed, and others are in the test stage. These forms cover all the institution's service programs.

* They presently have information that is more truthful, accurate and appropriate for use in the decision making process.

4.1.3. Administrative System

The administrative system in general, and especially the financial part, has benefited from the installation of the accounting applications, budget, inventory, bank reconciliation, CAS, payroll, check processing, word processing, etc.

Furthermore, a seminar, supported financially by the project, was given that strengthened concepts, elements and principles of supervision and motivation.

4.2. ADOPLAFAM

The project has collaborated in the institutional development of ADOPLAFAM in the following manner:

- Administrative and financial restructuring of the institution.
- Design and installation of an accounting system, including inventories and their respective automation.
- Assistance in the processing of contracts with community doctors.
- Staff training in different administrative and technical areas including budget and inflation.
- Planning and programming.
- Identification of mechanisms to increase revenue and sustainability.
- Standardization of the CYP concept.
- Donation of equipment for the systematization of information.

DAI has substantially increased its support to ADOPLAFAM in the last year.

4.3. Maternity Hospital Nuestra Senora de la Altagracia

Even though administratively the activities of the project belong to the hospital, one can see that, thanks to the support received from AVSC, the hospital is offering high quality service, more coverage and more efficiency. Logically, it can improve even more and that is the desire of the project directors. To improve training, a course on controlling hospital infections for doctors and nurses is being considered.

4.4. ONAPLAN

This institution has received support in equipment, training and technical assistance for the development of the activities that were already mentioned. Among those that stand out are the population projections; the creation of a poster and handbook which have met with great success and demand on behalf of the official and private agencies; the population bulletin; and the Socio-demographic Data Bank.

4.5. Conclusions

Thanks to the actions of the project, which not only has financed services, but also training, equipment and studies, the participating institutions' administrative capacities have grown, including their ability to program and plan, organize, develop and evaluate results.

It is difficult to quantify the immediate results obtained from these actions in terms of coverage and new acceptors, but undisputedly the result has been institutions that are more mature and more capable of continuing and expanding the offering of family planning information and services in the Dominican Republic.

Obviously, not all have the same level of institutional development; PROFAMILIA is much more advanced and bigger, it has more coverage and more programs; for now ADOPLAFAM can say that it is beginning, and the service at Nuestra Senora de la Altagracia Maternity Hospital is very localized and still has not integrated entirely into the hospital to be able to function as part of it afterwards.

However, if one wants these institutions to increase their coverage and reach the groups most in need, it is necessary to provide them with stronger, more dynamic administrative structures.

It was observed that close coordination to identify goals, program activities, resolve problems and evaluate results between the institutions has still not been achieved.

5. PROMOTION OF POPULATION POLICIES

Many of the project activities carried out in support of defining a population policy for the government of the Dominican Republic were mentioned in the sections pertaining to ONAPLAN and IEPD. It's important to add that, in addition to the DPE, other agencies, like PROFAMILIA, have for many years worked outstandingly to develop a varied range of efforts to promote the adoption of a population policy in the Dominican Republic.

Some of the people the evaluators visited were pessimistic about movement toward the adoption of an explicit population policy because of the present government in power. During 1994, the country will hold presidential elections. From now on, the different parties are in full campaign to get themselves known among the electorate and to get the votes needed to succeed the present government. PROFAMILIA has participated in meetings with advisors of the various political parties to share demographic information and results of studies done in the country.

Advisors close to the present candidates have been invited to international events (for example, the recent Latin American Symposium on Family Planning held in Mexico in November of 1992) to sensitize them to the theme of population and to assure that the next elected government has access to people who are informed on the topic. In the past, a group of Dominican congressmen had similar opportunities but their efforts were not fruitful.

It is important to recognize that the country, with a present population calculated at 7.6 million, will have 1 million more people in the year 2000, in spite of the reduction observed in the global fertility rate. This fact, the closeness of Haiti and the attraction of Dominican living conditions for those living near the border, the secret migrations of Dominicans to the United States through Puerto Rico, the low prevalence of effective contraception use by certain population groups such as teenagers, rural women and men, the persistence of induced abortions, which could range from 50,000 to 100,000 per year, etc. all constitute powerful reasons to maintain the momentum to promote the adoption of measures that would contain the unmeasured growth of such population groups.

5.1. Conclusions

One can conclude that the activities completed by ONAPLAN, DPE, IEPD and others and analyzed previously indicates that the development of a basic platform for the future formulation of a National Population and Development Plan received important support from the project. It is necessary to emphasize that, in general terms, the activities programmed within the project on this topic were carried out in their entirety.

6. INDICATORS

The evaluators were asked for an opinion on the use of the CYP as a measure or indicator of the results of the project, and then for recommendations on the use of other indicators for the next project.

6.1. General Considerations

In the first documents that appeared concerning this project, a goal was set of 300,000 new users; afterwards, it changed to Couple-Years Protection and this has remained the principal indicator.

The CYP is an indicator that is used to monitor the volume of activities of a family planning program, to measure the effectiveness and efficiency of the program, to determine the cost by means of an adequate assignment of expenditures, to compare the program in terms of volume of services offered, to measure the contribution of the program to increased contraceptive prevalence, etc.

The limitations of the CYP as an indicator include the following: the distribution of contraceptives does not necessarily mean use; it measures only the volume of contraceptives or services offered, and not the quality of use or of knowledge; and, in the case of condoms, not everyone uses them for family planning purposes. Sometimes they are used to prevent sexually transmitted diseases.

Because of the above, the evaluators recommend using different indicators. These indicators must be determined beginning with the planning stages of the project. Furthermore, all institutions involved must understand them and know how to calculate them. Some examples of indicators that can be used are the following:

* **Indicators of volume of family planning services:**

  - Methods distributed by type and by project (CYPs);
  - New users, for which there must be a single definition applied uniformly. It can be by method, service, etc.
  - Number of consultations by type;
  - Number of community-based distribution promoters by area and zone;

- Number of post-partum or post-miscarriage acceptors;
- Courses by topic;
- People trained, by topic;
- Staff trained, by profession or position;
- Trained promoters;
- People informed on family planning;
- Number of talks;
- Number of publications made;
- Number of publications distributed;
- Number of men attended to;
- Number of adolescents trained as leaders or communicators;
- Number of adolescents informed about sex education or family planning;
- Number of tubal ligations or IUD post-partum, post-miscarriage, or between pregnancies, by program.

* **Indicators of coverage of family planning services:**

These are measured relative to the number of people the service intends to reach:

- Proportion of women of fertile age or in relationships who are familiar with or use family planning methods, by types of methods;
- Proportion of daily or monthly consultations by type and by institution;
- Changes in the knowledge and attitudes of adolescents, their parents or teachers, regarding family planning;
- Proportion of people (women, men or adolescents) in rural areas and by region who use methods.

* **Indicators of the efficiency of family planning actions:**

These indicators reflect the relative effort to achieve the goal. Generally, they are measured in terms of cost incurred in the procedure.

- Cost per CYP by method and by project;
- Cost per service offered;
- Cost per person trained;
- Cost per man attended to;
- Cost per adolescent informed or attended to.

One could enumerate other possible indicators to use in a new project. However, to determine the definitive ones to use requires knowing the goals and objectives to be reached, as well as the procedures that must be developed for the achievement of these goals or objectives, the form in which the schedule will develop, how the project will be evaluated, etc.

It is equally important to establish some indicators of quality, such as the type of information or orientation supplied to the users, the type of user files they have, the technical competence of the staff, as well as their capability and skill, the existence of procedure or rule manuals, the type of interpersonal relations, measurment of rates of continuity of use, follcw up systems, the location of services, security of said services, the appearance of the installations, etc. These indicators, although they are qualitative rather than quantitative, should also be considered.

The indicators that have been described are related to programs or family planning activities; if the project that is going to be established also has maternal-child and AIDS components, it is necessary to establish indicators to measure such activities and their impact, such as:

- Number of pregnancy, post-partum, gynecological, and other consultations;
- Number of post-partum and post-miscarriage expenditures;
- Number of consultations by doctors or professionals and by unit;
- Number of children attended, by cause of the consultation;

- Number of vaccinations supplied;
- Number of hospital beds available and by specialization;
- Coverage of services;
- Efficiency of services (relative to costs);
- Number of talks, courses and training sessions;
- Number of people trained, educated or informed;
- Quality of services;
- Laboratory tests done.

One could make an endless list of indicators but, to determine the definitive ones, it would be necessary to know the concept of the project: the main objective, the secondary one, the goals, strategies, procedures to use, etc.

One very important factor in the identification of indicators is the establishment of specific goals. If they are not well-defined, it is very difficult to choose indicators to use. This is one of the most important problems that this project has had and there also lies the difficulty of its evaluation. The goal must be fixed in terms based not only on historic results, but also on the target population to be served and the changes that are sought. These goals must, above all, be realistically in agreement with the available resources and the size and degree of development of the institutions. As a consequence, the goals must be reachable and not determined with an exaggerated optimism. Lastly, the goals must be measurable. That is to say, they must only be fixed in quantitative terms. Sometimes, one may want to change some qualitative variables. Whenever possible, one must define well how changes and results are going to be measured.

6.2. Fulfillment of Project Goals

The quantitative goals of the project broken down by institution and by component first appeared in the first amendment of the project (7/12/90), and later were adjusted when the project was extended to June 25th, 1992. These changes led to incomplete communication between AID and the institutions, causing confusion and misunderstanding, especially in the case of PROFAMILIA. Similarly, the inclusion of the results obtained through the buy-ins related to PROFAMILIA was not clearly defined.

The relationship between the goals and achievements of the components of PROFAMILIA appear in Chart 13. The results go up to November 30, 1992.

The goals and achievements of ADOPLAFAM, ONAPLAN and MNSA appear in Charts 14, 15 and 16 respectively. These results presented go up to December 31, 1992.

The goals of all the institutions are the ones assigned up to the termination of the project (August 31, 1993).

In general terms, almost all the goals will be fulfilled and in some cases surpassed.

7. DEVELOPMENT ASSOCIATES

7.1. Technical Assistance

The most important function that DAI had during the development of the expansion project was technical assistance to prepare the institutions and their officials to assume complete and effective future management of the programs. To this end, it set as a goal the institutional development of the agencies so that they could better offer family planning services and increase their coverage.

The technical assistance has been divided into long-term assistance supplied by the foreign and national officials of the project and short-term technical assistance. The DAI staff consists of a director (chief of party); two specialist coordinators; a financial specialist; an information systems specialist; and a research specialist. A project assistant, two part-time secretaries, a janitor and a driver were also contracted.

The director as well as the specialists have as their main job the provision of continual technical assistance to the institutions. DAI contributed specifically in carrying out the following, among others:

- Development of the Information Systems of PROFAMILIA and ADOPLAFAM.
- Participation in demographic studies such as "Social Indicators in the Housing of Sugar Cane Workers (bateys)."
- The Demographic and Health Survey (DHS) of 1991.
- The Socio-demographic Data Bank.
- The Family Planning Unmet Needs Study.
- The Development of the Financial and Administrative System of ADOPLAFAM (training, assembly and monitoring).

The short term technical assistance by the international consultants was done in the following manner:

-	Programming and evaluation	1.5 months
-	Training and human resource development	2.5 months
-	Information, communication and materials preparation:	
	* publicity	2.0 months
	* financial	1.5 months
-	Administration and organization of programs	2.5 months
-	General information systems	5.0 months
-	Policy development	3.0 months
	Total	18 months

Equally, 1,886 local consultant days were contracted, totalling 94 months.

Some of the above mentioned aspects are expanded upon later in this document to show the fulfillment of technical assistance.

PROFAMILIA received technical assistance to improve the operating efficiency of its Santo Domingo and Santiago Clinics. DAI facilitated a study to establish the operational costs of the laboratory that functions in the Evangelina Rodriguez Clinic. This study indicated that further increases in cost recovery for laboratory services could not continue.

The support offered by DAI for PROFAMILIA to undertake the "Family Planning Unmet Needs," and DAI's own efforts to contract out the work on "Myths and Beliefs in Family Planning" and "Family Planning and Social Indicators in the Bateys", are further demonstrations of the interest shown in searching out unserved population groups. Their goal was to improve the information to the participating agencies, and by extension to the government and other agencies, on the reasons why such groups have not participated, thus enabling them to design specific actions to cover their needs.

The bateys study, for example, served so that the State Sugar Council, together with support from the United Nations Population Activities Fund (UNPAF) is presently developing a program directed at providing family planning services to the sugar cane workers population living in the bateys.

Putting the TECAPRO Clinic Administration Model into effect could improve the flow of people to the clinics of Santo Domingo even more, as well as improving the efficiency of the operations and the capacity of offerings of both clinics.

Indirectly, the computers furnished by the project, the accounting and statistics program packages, etc. will free the PROFAMILIA and ADOPLAFAM technicians from some of their duties so that they can dedicate more time to the programming and follow-up of distinct programs in the future. ONAPLAN benefitted from the programs and training as was already indicated.

ADOPLAFAM received training on how to improve their service statistics and how to incorporate the CYP indicator to monitor the family planning activities. Similarly, the technical staff of ADOPLAFAM received training on how to improve communication and channeling of clients to the services, among others.

7.2. Purchase of Equipment and Supplies

The Expansion Project made purchases of about US$700,206 (seven hundred thousand, two hundred and six) in vehicles and medical and office materials. For these purchases, DAI subcontracted the firm "American Manufactures Export Group" of Texas. The majority of equipment acquired was for PROFAMILIA.

Once the needs for equipment were assessed and the request sent to DAI, DAI verified the need for, along with the possible use of the equipment and if it was or was not viable in order to begin the purchasing process according to the federal regulations (Federal Acquisition Requirements). In 1990, DAI underwent an audit that found adequate fulfillment of the regulations in this area. The DAI office in Santo Domingo handles the entire financial and administrative process to make the monthly disbursements to ADOPLAFAM and ONAPLAN, but the final accounting is handled in the Washington, D.C. office.

The evaluators found that the global supervision or monitoring function of the project had not been identified and assigned to any specific institution.

7.3. Conclusions

It is without a doubt that the technical assistance benefited all the private sector agencies that participated in the project. DAI was an important partner in the growth that they experienced both organizationally and in their operations and programs.

Although the above stands out in the execution of the project, it must not be forgotten that a long road still remains ahead. The use of information generated by the accounting system to establish real costs of each activity, as seen, still does not permit its use to its full potential, especially in ADOPLAFAM. The same is true with the service statistics that are generated, inasmuch as they are collected but analyzed little both in ADOPLAFAM and PROFAMILIA.

The weakness of the actions for reaching adolescents, men, and groups of women still not covered, can also signal an area that did not receive enough attention.

The management of DAI's disbursements for ADOPLAFAM and ONAPLAN was efficient. It would have been desirable if that efficiency had extended to the A.I.D. disbursements corresponding to PROFAMILIA.

8. RECOMMENDATIONS

8.1. General

- Increase services to population areas and groups with low contraceptive prevalence and high unmet family planning needs, such as, for example, Regions IV and VI, rural areas, teenagers, and women with low education levels.

- Improve the contraceptive method mix.

- Organize special programs for men.

- Offer special reproductive health programs for teens.

- Strengthen the coordination among participating entities.

- Should the next project include primary health care, AIDS and other components besides family planning, it will be necessary to determine the components, goals and indicators clearly from the project design phase to facilitate its follow up and evaluation.

8.2 PROFAMILIA

- PROFAMILIA could consider the possibility of opening more institutional clinics in other cities of the country.

- The Evangelina Rodriguez Clinic can broaden its female sterilization service. The two clinics can and should increase their ultrasound services.

- Develop a study on the quality of services of both clinics, to make the changes necessary in those services, in accordance with the results.

- Study the quality of the Community-based Distribution Program and the Associated Clinics.

- Construct a surgical area for the Rosa Cisneros Clinic of Santiago.

- In the process of setting goals, take into account not only the historical trend (results), but also the target population to be served and the available resources.

- Continue perfecting the methodology to be applied in cost determination.

- PROFAMILIA must finish restructuring the Evaluation Department.

- Carefully supervise the quality of service statistics that are collected.

8.3. ADOPLAFAM

- ADOPLAFAM should intensify the efforts to improve local revenue and self-sufficiency to diminish its dependency on external help.

- ADOPLAFAM should make the necessary changes to its current accounting system to allow them to analyze costs per activity and per program. They should incorporate the costs of donated contraceptives, the cost of equipment, and the money they recover from sales of services in each component into the accounting system.

- ADOPLAFAM should study the efficiency (costs) of its programs, and based on the results, take the necessary corrective measures.

- All offices of ADOPLAFAM should operate in one place. The dispersion of the organization in three sites, which is the current situation, is inadvisable.

- It is important to establish, through operational research, if the primary health care component undertaken by ADOPLAFAM's vcha's does or does not affect the family planning activities.

- ADOPLAFAM should explore the possibility of cooperative work in family planning between themselves and some health institutions of SESPAS/CONAPOFA, social security, etc.

- They should identify their real information needs and based on those, design an adequate evaluation system.

8.4. MNSA

- The possibility of providing family planning services on weekends should be studied, since patients giving birth on Friday afternoons or Saturdays have little probability of receiving services.

- Local advice should be sought for developing programs to be used in the processing of the new clinical history.

- The time dedicated and the support functions of the existing staff including the educators should be studied so that they maximize their efficiency.

- The coverage of services should be expanded to a greater number of patients relative to the total annual expenditures per birth and miscarriage.

8.5. ONAPLAN

- Support to the DPE of ONAPLAN should be maintained so that they continue in their role as promoter of a population policy in the Dominican Republic.

- The DPE and NSO should work closely in the fields of population and family planning.

8.6. DAI

- Given that the project will end on August 31, 1993, and that DAI has complied with their commitments, no special recommendations are made.

8.7. A.I.D.

- AID should determine which institution will complete the global supervision or monitoring function of the next project.

- Alternatives that speed up the process of the disbursements to the institutions that participate in the next project should be considered.

- From the beginning, the components, activities, goals, and indicators that are included in the next project should remain clearly defined.

- Each change decided upon during the development of the project should be duly supported, documented and reported to the participants involved.

TABLE 1

PROFAMILIA
DR. EVANGELINA RODRIGUEZ CLINIC
OUTPUTS, 1987-NOV.1992

ACTIVITY	1987	1988	1989	1990	1991	1992	TOTAL
I. FAMILY PLANNING							
a) IUD's	925	1,247	1,049	1,076	1,901	1,668	7,866
b) Implants	423	189	274	760	1,092	1,601	4,339
c) Oral Contraceptives	38,927	21,979	17,099	11,649	11,011	11,449	112,114
d) Condoms	29,561	12,528	6,687	6,918	13,750	10,420	79,864
e) Vaginal Tablets	685	831	-	7,780	4,282	2,993	16,571
f) Foams	294	84	642	86	176	173	1,455
g) Fem. Sterilizations	-	-	443	883	1,632	1,908	4,866
II. CONSULTATIONS		21,891	26,491	24,185	25,223	27,681	135,335
a) Family Planning	(1)	(1)	(1)	6,502	9,645	14,819	30,966
b) Gynecology & STD's	9,708	13,485	15,530	6,951	5,177	3,252	54,103
c) Prenatal	11	572	1,842	2,900	2,006	1,550	8,681
d) Pediatric	145	7,834	9,319	7,832	8,395	8,060	41,585
III. LABORATORY	805	11,239	19,646	16,802	16,176	14,361	79,029
a) Pap Smears	805	6,539	5,330	4,972	4,400	4,704	26,750
b) Clinical	0	4,700	14,316	11,830	11,776	9,657	52,279

(1) Gynecological and Family Planning consultations were combined.

TABLE 2

PROFAMILIA
DR. EVANGELINA RODRIGUEZ CLINIC
OUTPUTS, 1987-NOV.1992

ACTIVITY	1987	1988	1989	1990	1991	1992	TOTAL
I. FAMILY PLANNING							
a) IUD's	332	729	842	502	1,243	920	4,568
b) Implants	-	13	25	27	217	366	648
c) Oral Contraceptives	3,018	9,489	16,222	12,990	14,429	13,784	69,932
d) Condoms	1,600	27,415	8,693	9,294	17,732	24,958	89,692
e) Vaginal Tablets	-	114	-	2,520	2,033	1,412	6,079
f) Foams	-	9	222	47	103	97	478
Referrals for Female Sterilizations	468	833	313	361	396	479	2,850
II. CONSULTATIONS	8,572	20,890	29,796	27,891	32,337	26,333	145,819
a) Family Planning	(1)	(1)	(1)	3,674	6,403	4,141	14,218
b) Gynecology & STD's	5,020	11,578	15,357	8,221	5,027	5,648	50,851
c) Prenatal	892	2,789	4,962	7,217	12,754	10,057	38,671
d) Pediatric	2,660	6,523	9,477	8,779	8,153	6,487	42,079
III. LABORATORY	8,006	23,441	29,821	23,701	22,800	16,457	124,226
a) Pap Smears	1,720	4,693	5,053	4,240	4,953	3,821	24,480
b) Clinical	6,286	18,748	24,768	19,461	17,847	12,636	99,746

(1) Gynecological and Family Planning consultations were combined.

TABLE 3

PROFAMILIA
COMMUNITY-BASED DISTRIBUTION OF CONTRACEPTIVES (CBD)
OUTPUTS, 1988-NOV 1992

	1988 \1	1989	1990	1991	1992	TOTAL
CBD PERSONNEL						
Community Technicians	9	9	12	14	14	14
Promoter Supervisors	-	-	48	49	54	54
Volunteer Promotors (vcha's)	463	581	558	772	808	808
I. FAMILY PLANNING METHODS DISTRIBUTED						
c) Oral Contraceptives	100,495	286,470	341,688	403,256	371,273	1,503,182
d) Condoms	116,444	73,613	181,126	239,602	184,832	795,617
e) Vaginal Tablets	1,450	290	3,914	13,690	18,010	37,354
f) Foams	403	5	234	1,322	1,901	3,865
II. REFERRALS						
g) Female sterilizations	1,107	1,343	1,192	1,555	2,365	7,562
h) IUD's and implants	53	111	189	302	425	1,080
i) Pap smears & other	1,578	1,313	1,843	2,073	4,489	11,296

\1 For second semester only, corresponding to period when project support began

TABLE 4

PROFAMILIA
COMMUNITY-BASED DISTRIBUTION OF CONTRACEPTIVES (CBD)
CBD WORKERS, DEC. 1992

REGION	COMMUNITY COORDINATORS	PROMOTER SUPERVISORS	PROMOTERS TOTAL	PROMOTERS URBAN	PROMOTERS RURAL
TOTAL	14	54	808	626	182
SOUTHERN REGIONS	8	23	391	324	67
-Region 0	4	9	127	125	2
-Region I	1	3	51	34	17
-Region IV	1	2	36	31	5
-Region V	1	6	139	107	32
-Region VI	1	3	38	27	11
NORTHERN REGIONS	6	31	417	302	115
-Region II	4	17	228	154	74
-Region III	1	10	117	91	26
-Region VII	1	4	72	57	15

TABLE 5

PROFAMILIA
ASSOCIATED CLINICS
OUTPUTS, 1987-NOV.1992

ACTIVITY	1988	1989	1990	1991	TOTAL
	40	47	64	81	81
I. FAMILY PLANNING					
a) IUD's	176	200	348	720	1,444
b) Implants	6	66	137	230	439
c) Oral Contraceptives	1,063	3,986	8,150	23,113	36,312
d) Condoms	1,584	3,062	7,488	20,831	32,965
e) Vaginal Tablets	-	-	-	1,665	1,665
f) Foams	-	-	-	101	101
g) Female Sterilizations	\1	7,533	7,349	5,252	20,134
h) Vasectomies	\1	37	20	8	65
II. CONSULTATIONS	11,898	20,824	24,665	28,495	85,882
a) Pap Smears	2,727	6,714	3,393	10,593	23,433

\1 Not financed by the project.

TABLE 6

PROFAMILIA
SOCIAL MARKETING PROGRAM
CONTRACEPTIVES DISTRIBUTED, JULY 1990-NOV. 1992

	1990	1991	1992	TOTAL
FAMILY PLANNING METHODS				
a) IUD's	1,400	5,389	4,200	10,989
b) Implants	-	-	187	187
c) Oral Contraceptives	189,559	533,649	557,164	1,280,372
d) Condoms	275,524	1,002,551	1,464,623	2,742,698

Data are for the whole program, not just the part financed by the Expansion Project

The IUD's are donated by AID but are received through the IPPF.

TABLE 7

PROFAMILIA
COUPLE YEARS OF PROTECTION PROVIDED
1987 - NOV.1992

	1987	1988	1989	1990	1991	1992	TOTAL
TOTAL CYP'S	8,930	18,273	138,972	167,191	205,561	132,393	671,321
EVANGELINA RODRIGUEZ CLINIC	7,556	6,593	11,882	19,233	33,386	38,076	116,727
ROSA CISNEROS CLINIC	1,374	3,416	4,204	2,803	6,219	5,610	23,626
ASSOCIATED CLINICS	0	719	103,283	101,703	76,013	0	281,717
SOCIAL MARKETING	0	0	0	19,390	61,173	62,330	142,893
COMMUNITY BASED DISTRIBUTION	0	7,547	19,603	24,062	28,770	26,376	106,358

CYP FACTORS:	IUD's	Implants	Pills	Condoms	Tablets	Foams	Female Steril.
	3.5	3.5	0.0667	0.0067	0.0067	0.1333	13.50

TABLE 8

ADOPLAFAM
COUPLE YEARS OF PROTECTION, 1991-92

PROGRAM	1991	1992	TOTAL & PERCENT
COMMUNITY DOCTORS	3,512	4,148	7,660 31%
VOLUNTEER COMMUNITY HEALTH AGENTS (VCHA'S)	3,901	6,960	10,861 44%
BEAUTY AND BARBER SHOP OPERATORS	1,977	3,913	5,890 24%
TOTAL	9,390	15,021	24,411

SOURCE: ADOPLAFAM, 1991 ACTIVITIES REPORT
ADOPLAFAM REPORT FOR SEPT.-DIC./92

TABLE 9

ADOPLAFAM
A.I.D. SUPPORT RECEIVED AND COSTS RECOVERED
THROUGH SALES OF SERVICES AND CONTRACEPTIVES

CONTRIBUTIONS	1991	1992	TOTAL
A.I.D. SUPPORT	95,662	138,069	233,731
PERCENT	91%	80%	
COSTS RECOVERED THROUGH SALES OF EQUIPMENT AND CONTRACEPTIVES	9,672	34,224	43,896
PERCENT	9%	20%	
TOTAL	105,334	172,293	277,627

Source: ADOPLAFAM Finance Department

\1: Does not include A.I.D. donated equipment or technical assistance received.

TABLE 10

ADOPLAFAM
COST PER COUPLE YEAR PROTECTION \1
(US$)

		A.I.D. SUPPORT \2	CYP'S	COST/ CYP
COMMUNITY DOCTORS	(91)	$47,831	3,512	$13.6
	(92)	$69,035	4,148	$16.6
VOLUNTEER COMMUNITY HEALTH AGENTS	(91)	$23,915	3,901	$6.1
	(92)	$34,517	6,960	$4.9
BEAUTY AND BARBER SHOP OPERATORS	(91)	$23,915	1,977	$12.1
	(92)	$34,517	3,913	$8.8

\1: Does not include donated equipment or contraceptives.

\2: Contributions to the Project during 1991 and 1992 were $ 95,662 a $138,069, respectively. ADOPLAFAM distributed funding as follows: Community Doctors (50%), Beauty and Barber Shop Operators (25%), a Community Agents (25%)

Source: Information provided to evaluation team by ADOPLAFAM Finance and Service Departments

TABLE 11

PROFAMILIA
COST PER COUPLE YEAR PROTECTION
1988 - NOV.1992
(RD$)

	1988	1989	1990	1991	1992
EVANGELINA RODRIGUEZ CLINIC	47.06	45.44	48.20	50.20	33.65
ROSA CISNEROS CLINIC	61.93	85.84	196.07	234.77	197.48
COMMUNITARY BASED DISTRIBUTION	18.20	22.71	55.69	83.47	90.37
ASSOCIATED CLINICS	1.70	4.17	1.98	5.64	-

TABLE 12

PROFAMILIA
PERCENTAGE OF INCOME TO EXPENDITURES \1
(COST RECOVERY)
1988 - NOV.1992

	1988	1989	1990	1991	1992	87-92
EVANGELINA RODRIGUEZ CLINIC	25	52	60	54	74	58
ROSA CISNEROS CLINIC	59	67	69	49	67	60
COMMUNITARY BASED DISTRIBUTION	19	27	23	17	15	18
ASSOCIATED CLINICS	2	5	19	16	-	11
SOCIAL MARKETING \2	-	-	-	41	44	43
TOTAL FOR PROJECT	29	43	48	39	50	44

\1 Includes only service activities of the project and does not include indirect costs.

\2 Only the part directly corresponding to the project (condoms).

TABLE 13

PROFAMILIA
GOALS AND ACCOMPLISHMENTS
1987-NOV.1992

	GOAL	ACHIEVED	% COMPLETED	CYP's GOAL	CYP's ACHIEVED	CYP's % COMPLETE
COMMUNITY TECHNICIANS	14	14	100.00	-	-	-
PROMOTER SUPERVISORS	58	54	93.10	-	-	-
DISTRIBUTION SITES	867	808	93.19	-	-	-
OWN CLINICS	3	2	66.67	-	-	-
ASSOCIATED CLINICS	85	96	112.94	-	-	-
SOCIAL MARKETING PHARMACIES AND CONVENIENCE STORES	1,200	1,638	136.50	-	-	-
I. FAMILY PLANNING						
a) IUD's	16,782	24,867	148.18	58,737	87,035	148.18
b) Implants	5,949	5,613	95.97	20,472	19,646	95.97
c) Oral Contraceptives	2,876,533	3,001,912	104.36	191,865	200,228	104.36
d) Condoms	5,214,282	3,740,836	71.74	34,936	25,064	71.74
e) Vaginal Tablets	76,033	61,669	81.11	509	413	81.14
f) Foams	-	5,899	-	-	786	-
g) Fem. Sterilizations	28,435	25,000	87.92	383,873	337,500	87.92
h) Vasectomies	152	65	42.76	1,520	650	42.76
Referrals						
a) Fem. Sterilizations	15,859	10,412	65.65	-	-	-
b) IUD's and Implants	2,156	1,080	50.09	-	-	-
c) Pap Smears and other tests	-	11,296	-	-	-	-
II. CONSULTATIONS	462,271	281,154	60.82	-	-	-
a) Family Planning	-	45,184	-	-	-	-
b) Gynecology and STD's	-	104,954	-	-	-	-
c) Prenatal	-	47,352	-	-	-	-
d) Pediatric	-	83,664	-	-	-	-
III. Laboratory	266,664	232,688	87.26	-	-	-
a) Pap Smears	92,780	80,663	86.94	-	-	-
b) Clinical tests:	-	152,025	-	-	-	-
- Pregnancy	-	11,726	-	-	-	-
- Syphilis	-	16,266	-	-	-	-
- Urinalysis	-	37,809	-	-	-	-
- Blood	-	37,539	-	-	-	-
- Stool	-	20,165	-	-	-	-
- Blood type	-	8,160	-	-	-	-
- Blood sugar	-	13,182	-	-	-	-
- Other	-	7,178	-	-	-	-

PROFAMILIA
GOALS AND ACCOMPLISHMENTS
1987-NOV.1992

ACTIVITY	GOAL	ACHIEVED	PERCENT COMPLETED
IV. VACCINATION	-	20,831	-
a) Polio	-	5,539	-
b) D.P.T.	-	5,634	-
c) Tetanus	-	6,664	-
d) B.C.G.	-	1,754	-
e) Measles	-	1,240	-
V. SPECIALIZED SERVICES	-	3,432	-
a) Biopsies	-	232	-
b) Ultrasound	-	2,008	-
c) Cauterizations	-	1,015	-
d) Diagnostic Laparoscopies	-	177	-
1. PROMOTION AND MOTIVATION			
a) Workshops for multipliers/ satisfied users	-	121	-
b) Community talks	21,950	6,054	27.58
b) Talks and other activities with base groups	-	8,504	-
c) Home visits	13,804	11,948	86.55
d) Brochures distributed to companies, institutions, and private doctors \1	-	2,622	-
e) Other	-	2,116	-
f) Referrals	-	750	-
g) Promotional Visits to Companies and Institutions	-	826	-
2. EDUCATION AND INFORMATION			
a) Within-clinic talks	5,357	4,054	75.68
b) Promotional fliers	-	57,626	-
b) Educational materials	514,136	393,680	76.57
c) Counseling sessions	42,220	33,265	78.79
d) Video cassettes	-	4	-
e) Orientations	-	2,017	-
f) Radio activities	27,778	12,608	45.39

\1 Corresponds to units distributed, not target population

TABLE 14

ADOPLAFAM
GOALS AND ACCOMPLISHMENTS
(1991-92)

Activities	Planned	Accomplished
1. Family Planning Services		
1.1 Methods distributed		
a) IUDs	1,556	355
b) Pills	162,214	99,952
c) Condoms	471,059	
d) Oral contraceptives	39,708	5,013
e) Female Sterilizations	256	121
1.2 Referrals for IUDs and sterilizations	925	1,667
1.3 Various consultations (FP,MC)	78,400	50,547
1.4 Pap Smears	3,422	2,130
2. Family Planning Services:		
2.1 Community Doctors	50	57
2.2 Community Volunteers (vcha's)	450	416
2.3 Beauty Parlours	200	167
2.4 Barber's Shop	100	40
3. Information, Education, Communication		
3.1 Educational Sessions	680	964
3.2 Counseling Sessions	1,500	1,583
3.3 Home Visits	5,370	4,813
4. Cost recovery ratio	20%	20% (92)

TABLE 15

NATIONAL PLANNING OFFICE, POPULATION AND EMPLOYMENT DIVISION
(ONAPLAN, DPE)
GOALS AND ACCOMPLISHMENTS -- DEC/1992

ACTIVITIES	Planned	Accomplished
1. Creation of the Inter-Institutional Committee for Population Projections	1	1
2. Statement about Population and Development in the D.R. Declaration related to the role of the DPE	2	2
3. Personnel Training	9	9
4. Demographic Projections	4	4
5. Elaboration of Catalogue related to Population Projections	1	1
6. Population Projections Poster	1	1
7. Workshops on use of Demographic data for Planning	3	3
8. Demographic data bank	-	1
9. ONAPLAN DPE Bulletins	7	5
10. Support in analysis of 1991 DHS	1	1
11. Monographs with DHS analysis	3	-

TABLE 16

MATERNITY HOSPITAL NUESTRA SENORA DE LA ALTAGRACIA (MNSA)
OUTPUTS

	Goals	Achievements
1. Family Planning Services		
1.1 Female Sterilizations	6,000	3,153
1.2 IUD's	3,000	1,557
2. Amb. Postpartum Consultations	9,000	NA
3. Personnel Training		
3.1 Residents	100	NA
3.2 Interns	700	NA
3.3 Medical Students	700	NA

NA = data not available

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